



COUNTY COUNCIL OF DEVON



ANNUAL REPORT

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

FOR THE YEARS

1968 and 1969



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DEVON HEALTH COMMITTEE

as at 31st December, 1969

Health Committee

Chairman: †Rev. J. W. Timms.

Vice-Chairman: ‡Mrs. M. Owen.

Chairman of the Council (ex officio)

Vice-Chairman of the Council (ex officio)

Chairman of the Finance Committee (ex officio)

Mr. Clarke	Mrs. Patt	Mr. Rose
Mr. Daymond	Mr. Payne	Mr. Scoble
Mrs. Gibbens	§Mrs. Perkin	Mr. Staddon
Rev. F. J. H. Hendy	Mr. Prowse	||Mr. Thomas
Mrs. Hindson	Mrs. Quinnell	Mr. Tucker
Major Jackson	Mrs. Ratcliffe	
Mr. Jones	Mr. Ridd-Jones	

Nominated by the following bodies:

Community Council of Devon—Dr. A. Robinson Thomas

Devon Branch, British Red Cross Society—Major J. C. D. Jarrad, M.B.E.

Devon Branch, St. John Ambulance Brigade—*Major T. W. Gracey

Devon and Exeter Local Dental Association—Mr. G. Pendlebury

Devon and Exeter Local Medical Committee—Dr. R. M. S. McConaghey,
O.B.E., Dr. G. C. C. McVicker

Devon and Exeter Pharmaceutical Committee—Mr. H. Jarvis Graves

Executive Council for Devon, Exeter and Torbay—Mr. A. D. J. Harvey

Women's Royal Voluntary Service—Mrs. R. Croft, M.B.E.

* Chairman of Ambulance, † General Purposes, ‡ Adult Health, || Child Health and § Nursing sub-committees.

INTRODUCTION

HEALTH DEPARTMENT,
COUNTY HALL,
EXETER

October 1970

To : The Chairman, Aldermen and Members
of the Devon County Council.

Mr. Chairman, My Lord,
Ladies and Gentlemen,

I have the pleasure of presenting my statutory report which on this occasion is biennial (covering 1968 and 1969) instead of annual. This is done for the purpose of economy and to enable the clerical and administrative staff to devote more of their time to their primary day-to-day responsibilities. Partly for the same reason the report has been streamlined and I hope rendered easier to read. It will be noted in particular that most of the detailed statistics are contained in a separate appendix in the final pages.

The report contains details of the services provided by the health committee for the prevention of illness, promotion of health and the care and after care of persons in the community, and by the education committee in respect of the school health service.

The most noteworthy feature of the vital statistics of the area is the extraordinary low level of perinatal (infant) mortality, viz. 18.6 per thousand births with a 5-year average (1965-69) of 19.7. The corresponding figures for England and Wales are 23.4 and 25.5. Residence in Devon would appear to be a distinct advantage for the unborn and newly born child, but it would be wrong to attribute this to our favoured environment. The improved position in Devon relative to the rest of the country has occurred only within the last ten years. It is a direct result of the higher standards of ante-natal and obstetric care which prevail in the county. The credit for this must go to obstetricians, paediatricians, general practitioners, midwives and health visitors who not only function more efficiently than previously but also co-ordinate their efforts more satisfactorily. Expectant mothers too deserve congratulation for their increased readiness to accept advice and education at clinics and health centres.

The standard of health of older children is also generally good, but closer reading of my report on the school health service gives no cause for complacency. One in five of the children examined had at least one condition or

defect requiring treatment. Most of these conditions were minor (though not trivial), but it is necessary to note that no fewer than 1,184 school-children are sufficiently handicapped to require some “special educational treatment”, i.e. special educational arrangements in ordinary or special schools. The total number of such handicapped pupils unfortunately shows no sign of reduction though trends in individual categories reveal considerable variation.

The dental health of school-children remains unnecessarily poor. The worst ravages of excessive dietary carbohydrate are prevented by the skill and zeal of our dental officers. Every effort is made to educate parents and children in dental hygiene but, as with cigarette smoking in adults, it is difficult to make any rapid progress when faced with entrenched attitudes and habits. Fluoridation of water supplies would undoubtedly transform the situation but is clearly not acceptable at present to the county council.

A separate section of my report is devoted to services provided for the elderly all of which have had to expand rapidly in recent years to meet the growing needs. The load falls on district nurses, health visitors, chiropodists, occupational therapists, home helps, social workers, ambulance staff and others all of whom work in close co-operation with family doctors and hospital personnel.

This co-operation with the other two branches of the National Health Service has been the most important feature of the development of the county council’s health services in the past five years. It is evidenced in the increased “attachment” of nursing staff to family doctors and in the growth of health centres where general practitioners and other county staff can work together as a team under one roof in order to ensure a better and more economic service for the patients.

I hope that the new format of my report will make for interesting and informative reading and that it will be useful as a book of reference.

I wish to thank members of the health committee for their continued and unwavering support which has enabled so much of value to be achieved, and to pay tribute to the devotion, loyalty and energy of the health department staff.

J. LYONS
County Medical Officer and
Principal School Medical Officer

STAFF OF THE HEALTH DEPARTMENT

County Medical Officer and Principal School Medical Officer	J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.
Deputy County Medical Officer and Deputy Principal School Medical Officer	D. S. Parken, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.H.
Senior Medical Officer for Maternal Health and Nursing	F. Gloria Richards, M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G.
Senior Medical Officer for Child Health	D. O. McKnight, M.B., B.S., D.C.H., D.P.H.
Senior Medical Officer for Adult Health	J. A. Theobald, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
Senior Medical Officer	D. Cullen, M.B., B.S., L.R.C.P., M.R.C.S., D.P.H.
Chief Nursing Officer	Miss A. Varley, S.R.N., S.C.M., H.V.C., Q.N.
Superintendent Health Visitor	Miss E. L. Hunter, S.R.N., C.M.B., (Pt. I), H.V.C.
Health Education Officer	Miss P. O. Davies, R.M., D.H.ED.
County Health Inspector	M. S. Powling, F.A.P.H.I., M.I.P.H.E.
Lay Administrative Officer	J. Cooke
Chief Clerk	H. T. Baldwin
County Ambulance Officer	R. P. Selley, D.P.A., F.I.A.O.
Home Help Organiser	G. P. Brooks, D.P.A., D.S.A.
Principal Social Worker	L. H. Jenkins, A.A.P.S.W., D.S.S., M.S.W.
Senior Occupational Therapist	Miss M. M. Keily, M.A.O.T.
Chief Chiropodist	W. Beedle, M.Ch.S., R.M.A.
Senior Workshop Manager	T. O. Hughes, D.M.A.
Administrative Officers:	
Adult Health Section	P. Brady
Child Health and Nursing Section	K. G. Baker
General Section	P. M. Milton

MEDICAL OFFICERS

L. G. Anderson, M.D., Ch.B., D.P.H.	}	“mixed” appointments
M. E. Budding, B.Sc., M.B., Ch.B., D.P.H.		
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P.		
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.		
A. H. Halstead, M.B., B.S., D.P.H.		
R. C. MacLeod, M.D., D.P.H., D.T.M. & H		
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.		
E. Williams, M.R.C.S., L.R.C.P., D.P.H.		
J. Allott, M.B., Ch.B., D.P.H.		
R. M. Beasley, M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (part-time)		
E. A. Chalk, B.A., B.M., B.Ch. (part-time)		
J. D. M. Dawson, M.B., B.S. (part-time)		
M. J. Dunn, M.B., Ch.B.		
J. M. Hall, M.B., B.S., D.P.H. (part-time)		
F. H. Lamb, Surgeon-Captain, M.R.C.S., L.R.C.P. (part-time)		
G. M. Lea-Wilson, B.M., B.Ch. (part-time)		
R. B. Mayfield, M.R.C.S., L.R.C.P., M.B., M.D., D.P.H. (part-time)		
J. M. Shields, M.B., B.S., M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (part-time)		
E. R. Smith-Owen, M.R.C.S., L.R.C.P., M.B., Ch.B. (part-time)		
L. W. Waters, M.B., Ch.B. (part-time)		

School Ophthalmic Surgeons*

A. M. Barnett, M.A., M.R.C.S., L.R.C.P., D.O.
R. C. Chaturvedi, M.B., B.S., D.O.
A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.
G. Searle, M.R.C.S., L.R.C.P., D.O.

Chest Physicians*

G. E. Adkins, M.B., B.CHIR.
J. J. Y. Dawson, M.C., M.D., M.R.C.P.
R. L. Midgley, M.R.C.S., M.R.C.P., M.B., B.S., M.D.
J. T. Smyth, M.R.C.S., M.R.C.P., M.B., B.S.

Psychiatrists, Child Guidance*

C. J. Wardle, M.D., B.S., M.R.C.S., L.R.C.P., D.P.M.
P. M. Jackson, M.B., B.Ch., D.P.M.

* On staff of the Regional Hospital Board.

DENTAL SERVICE

Chief County Dental Officer and

Principal School Dental Officer .. F. H. Stewart, B.D.S. (w.e.f. 1.1.68)

County Orthodontist J. D. W. Barnett, B.D.S., D.ORTH.

Dental Officers (full-time):

G. W. B. Bateman, L.D.S., R.C.S.

Kathleen Billings, B.D.S.

G. J. Derbyshire, L.D.S. (transferred to Torbay 1.4.68)

J. L. Dickson, L.D.S., R.F.P.S.

D. J. Dolby, L.D.S., R.C.S. (w.e.f. 1.7.68)

A. R. Gammack, L.D.S., R.C.S.

H. W. Gibbs, L.D.S., R.C.S.

H. G. Hobdell, L.D.S., R.C.S. (transferred to Torbay 1.4.68)

J. F. Hunt, L.D.S., R.C.S.

C. T. Pomeroy, L.D.S., R.C.S. (resigned 30.6.68)

Gillian A. Rampton, L.D.S. (w.e.f. 18.11.68) (resigned 14.12.69)

A Shipley, B.D.S.

K. P. Smith, L.D.S., R.C.S.

J. W. Steer, L.D.S., R.C.S.

Valerie E. Street, B.D.S. (resigned 29.9.68)

C. N. van Rijswijk, B.Ch.D. (resigned 31.3.68)

J. K. Vowles, B.D.S.

F. M. Warren, B.D.S., L.D.S., R.C.S.

H. D. Williams, L.D.S., R.C.S.

Dental Auxiliary:

Mrs. R. Martin (transferred to Torbay 1.4.68)

Dental Hygienist:

Miss P. H. Turnage

DISTRICT MEDICAL OFFICERS OF HEALTH

Areas	District Councils		District Medical Officers of Health
1	Exmouth Budleigh Salterton St. Thomas	U.D. U.D. R.D.	L. G. Anderson, M.D., D.P.H. (“mixed” appointment)
2	Ottery St. Mary Sidmouth Honiton Seaton Axminster Honiton	U.D. U.D. M.B. U.D. R.D. R.D.	R. C. MacLeod, M.D., D.P.H., D.T.M. & H. (“mixed” appointment)
3	Crediton Crediton Tiverton Tiverton	U.D. R.D. M.B. } R.D. }	N. F. Sawers, M.B., ch.B. L. N. Jackson, B.A., D.M. G. Nicholson, M.D., D.P.H., F.R.C.S. (combined appointment)
4	Barnstaple Barnstaple South Molton Ilfracombe Torrington Northam Bideford Holsworthy Great Torrington Bideford Lynton	M.B. } R.D. } R.D. } U.D. } R.D. } U.D. } M.B. } R.D. } M.B. } R.D. } U.D. }	E. Williams, M.R.C.S., L.R.C.P., D.P.H. (“mixed” appointment) Stella C. Candler, M.B., ch.B., M.R.C.S., L.R.C.P. Deputy Medical Officer of Health C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P. N. B. Betts, M.B., B.Chir., F.R.C.S., L.R.C.P. M. P. Nightingale, M.R.C.S., L.R.C.P.
5	Salcombe Kingsbridge Kingsbridge Plympton St. Mary Tavistock Totnes Totnes Buckfastleigh Dartmouth	U.D. U.D. R.D. R.D. R.D. M.B. R.D. U.D. M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H. Mary E. Budding, B.Sc., M.B., B.Ch., D.P.H. Deputy Medical Officer of Health (“mixed” appointments)
6	Ashburton Dawlish Teignmouth Newton Abbot Newton Abbot	U.D. U.D. U.D. U.D. R.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H. A. H. Halstead, M.B., B.S., D.P.H. Deputy Medical Officer of Health (“mixed” appointments)
7	Okehampton Okehampton	M.B. R.D.	Mary E. Budding, B.Sc., M.B., B.Ch., D.P.H. (“mixed” appointment)

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Area and Population

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>
Area (acres)	102,187	1,510,148	1,612,335
Population (estimated mid-1968)	189,190	247,620	436,810
Population (estimated mid-1969)	192,070	247,350	439,420
Number of Municipal Boroughs, 8; Urban Districts, 16; Rural Districts, 16; Total, 40.			

On the 1st April, 1968, the County Borough of Torbay was created, consisting of the former Borough of Torquay, and the Urban Districts of Brixham and Paignton. At the same time there was some small rationalisation of the boundaries of areas affecting Totnes and Newton Abbot rural districts, with the result that the population of the administrative County of Devon was reduced by approximately 100,000 and the acreage by 14,093. The rural population, previously 47% of the whole, has now risen to 57%.

Vital Statistics

	<i>Administrative County</i>		<i>England and Wales</i>	
	1968	1969	1968	1969
<i>Live Births:</i>				
Number	6,039	5,954	819,272	797,542
Corrected rate per thousand population	17.00	16.60	16.9	16.3
Illegitimate live births (445) per cent of total live births	7.25	7.50	8.5	8.4
<i>Stillbirths:</i>				
Number	67	70	11,848	10,662
Rate per thousand total live and stillbirths	11.00	11.60	14.0	13.2
Total live and stillbirths	6,106	6,024	831,120	808,204
Infant deaths (deaths under one year)	77	89	14,982	14,397
<i>Infant mortality rates:</i>				
Total infant deaths per thousand live births	12.80	14.90	18.0	18.1
Legitimate infant deaths (81) per thousand legitimate live births	12.50	14.70	17.9	17.4
Illegitimate infant deaths (8) per thousand illegitimate live births	16.00	18.00	23.4	25.4
Neo-natal mortality rate (deaths under four weeks (51) per thousand total live births)	8.28	8.60	12.3	12.0
Early neo-natal mortality rate (deaths under one week (42) per thousand live births)	6.13	7.00	10.5	10.3
Peri-natal mortality rate (stillbirths and deaths under one week combined 109) per thou- sand total live and stillbirths)	17.03	18.60	25.0	23.4
<i>Maternal mortality (including abortion):</i>				
Number of deaths	2.00	0	200	*
Rate per thousand total live and stillbirths	0.33	0	2.4	*

* Figures not available.

PART II

CARE OF MOTHERS

Maternity Services

Domiciliary Midwifery

Family Planning

Care of Unmarried Mothers

Dental Care

CARE OF MOTHERS

Maternity Services

In the county 6,343 births were notified in 1968 and 5,942 in 1969. Details of domiciliary and institutional births, adjusted for transfers in and out, are set out below:

	1968	1969
Domiciliary	1,118	842
Institutional	5,225	5,100

Eighty-six per cent of all births in 1969 took place in hospitals or maternity units. A large proportion of these cases were discharged early to the care of the district midwives.

Ante-Natal Clinics

There are 41 ante-natal classes where health visitors and midwives teach relaxation and parentcraft. In some parts of the county evening sessions have been arranged so that interested fathers-to-be can attend. 2,142 mothers, representing about 35% of expectant mothers in the county, made 9,692 attendances at these classes. Attendances are high during the first pregnancy but few seem to recognise the need for refresher courses in succeeding pregnancies. Unfortunately many pregnancies come to our notice too late for the mother to attain the full benefit of this important teaching, as much advice that could be given is pointless late in pregnancy.

Ante-natal education will need in the future to include more information on family planning, with facilities for discussion with both wives and husbands.

Domiciliary Midwifery Service

The need for a unified midwifery service is apparent when we look at the changing pattern of the domiciliary midwifery service. During the last decade the national trend has been for mothers to choose to have their babies in hospital and this trend has been followed in the county. During 1969 14% of total births were home confinements. Of the 98 midwives employed in the county, 67 attended less than 10 deliveries. It is of increasing concern that the majority of domiciliary midwives do not have sufficient deliveries to retain their skills of practice.

In some areas the services of domiciliary midwives have been called upon to undertake deliveries in maternity units, due to shortage of staff. In one area the midwife has taken her own booked patients into hospital for the delivery, mother and baby returning home shortly afterwards, so ensuring continuity of nursing care. It is hoped that this arrangement will be extended in the future.

More midwives are now working alongside general practitioners at ante-natal sessions in surgeries and health centres. Mothers booked for hospital consultant wards, general practitioner units and domiciliary confinement are all seen jointly by doctor and midwife. This gives the mothers the opportunity of meeting their medical and nursing team, and previous time-wasting overlaps are avoided.

It is important that arrangements for early discharge from hospital are known well in advance. The midwife can then visit the home of all pre-arranged early discharges to assess the social conditions of the home, and to advise the mother on the preparation required when she returns home with her new baby. At this time, if domestic help is needed throughout this period to care for the

home and family, this can either be arranged privately, or through the home help service. Unfortunately, some mothers are still discharged early in the puerperium, without adequate provision being made in the home.

During the year all midwives employed in the county were given instruction on taking blood for the Guthrie test, replacing the phenistix testing of infants for phenylketonurea. This routine screening of all infants is carried out by either the hospital or domiciliary midwife on the child's seventh day. Blood from the infant is collected by heel prick on to a special absorbant filter paper. This blood test has replaced the urine test and is far more effective. It is hoped that all mothers will agree to this simple test being performed.

Family Planning

The close relations already existing between the Family Planning Association and the Devon County Council have been continued and discussions have taken place from time to time on extending the service.

1968 saw the closure of Dartington Centre which had been started many years ago and this was replaced by sessions at the Ashburton and Buckfastleigh Health Centres. Regrettably this has left Totnes itself without a centre. In 1969 a service started in the health centres at Okehampton and Torrington and these quickly became busy clinics.

The F.P.A. has free use of Devon County Council premises and the financial grant made has allowed for free consultations and supplies for patients seeking advice for medical reasons. The question inevitably arises whether this provision is adequate or whether, in ensuing years, considerable additional expenditure may be required.

Cervical Cytology

It would seem that far too small a proportion of the eligible women avail themselves of the facilities for the cervical smear test, and the additional check examinations which can be done at the same time. It is clear that special efforts are necessary to encourage women to attend for this purpose either at a local authority clinic or alternatively at the family doctor's surgery. Both the Dartmouth survey and a later one still in progress at the end of 1969 in a small rural town show the good results of concentrated drives. Similar results are shown in some practices which have carried out surveys and where general practitioners are anxious to carry out these surveys the Health Department gives all possible assistance.

The nine positive or suspicious cases of cancer found during 1969 afford good justification for this type of clinic, quite apart from the various other conditions that are found for which treatment is arranged through the family doctors. During the year 2,634 women attended the local authority cervical cytology clinics, making a total of 17,680 attendances since the service was first provided in 1965.

Care of Unmarried Mothers and their Children

During 1969 the Registrar General recorded 445 illegitimate births in the county area.

A small proportion of girls seek the anonymity of a mother and baby home and are content to have their children in a local maternity unit. This does not mean of itself any less work for the special case worker as the need for advice and support is unchanged but clearly there is a changing climate of public opinion, and it seems that more illegitimate children are being accepted into the family circle of the mother; short term foster homes are increasingly sought for those children whose mothers wish them to be placed for adoption.

St. Olave's Home at Exeter and South View at Plymouth both closed during 1969 after many years in which part of their work was concerned closely with the health of Devon girls. The remaining homes will, it is expected, meet the decreasing demand.

The county council continues to make an annual grant to the Exeter Diocesan Council for Family and Social Welfare towards the cost of the work of its social workers. During 1969 the Diocesan Council was concerned with 286 cases, 106 of which were referred by the Health Department. The number of cases admitted to mother and baby homes was 31. Twenty-one of these cases were admitted to St. Nicholas House, Exeter, where four places are reserved for Devon girls. In addition the county council accepted partial financial responsibility in respect of the maintenance of 10 girls in homes as follows:

St. Olave's Home, Exeter	.. 3
Southview, Plymouth	.. 2
Mayflower Home, Plymouth	.. 5

Dental Care of Expectant and Nursing Mothers

Expectant and nursing mothers are treated in county clinics "on demand" with health visitors and midwives referring those cases which are most in need of treatment. The number of mothers treated each year remains uniformly low, and it is assumed that most mothers seek treatment through the general practitioner service.

Most ante-natal classes in the county are now visited routinely by the Dental Hygienist for advice to mothers on the need for regular care of their own teeth and the teeth of their young children. While resultant benefits can only be measured in the long term, it is encouraging to note that most young mothers are now more aware than before of the importance of dietary care and maintaining good oral hygiene.

Dental inspection and treatment returns for Expectant and Nursing Mothers are quoted in Appendix ~~D~~ H

PART III

CARE OF CHILDREN

- A. Babies and Infants: Immunisation and screening procedures**
- B. Pre-school children: Dental care**
Nurseries and child minders
- C. Children of school age: Administration and records—School Health Service**
Premises: swimming pools
Health Visitor and school nurse
Health education
Periodic medical inspections
Child guidance
Hearing assessment
Speech therapy
Handicapped children
Dental care

CARE OF CHILDREN

A. Babies and Infants

There is room for a considerable increase in preventative care of the younger child and more especially for those children who are on the handicap or observation register or who are found to have needs in the field of emotional development. The aim behind developmental assessment work is to ensure that as far as possible every child entering school is physically, mentally and emotionally fit to take his or her place in community life.

All infants are visited by the health visitor as soon as possible after the tenth day, and further visits are made at intervals up to the age of 5 years. In the early weeks, infants are examined for possible dislocation of the hips and the urine is tested for phenylketonurea. At 6 to 8 months the health visitor carries out a simple hearing test and any doubtful cases are referred to the hearing assessment clinic after obtaining the agreement of the family doctor to this investigation. The health visitor works to maintain the standard of immunisation against infectious diseases and arranges for children entering school to have a heaf test to see if they have been in contact with a case of tuberculosis.

Immunisation

The number of children who received immunisation since 1948 are shown in Appendix G.

Tetanus

Older children who did not have the opportunity to receive tetanus immunisation in infancy, have in some areas been offered a full course of 3 injections. This involves a great deal of extra work for the medical officers concerned, but is very worth while.

Poliomyelitis

Vaccination against poliomyelitis is now offered to all persons who have not at the time of their application for vaccination reached the age of forty and also to special groups of personnel and their families who may come into contact with poliomyelitis cases. Oral vaccine is used but Salk vaccine can be made available if required. Persons going to visit or reside in a country outside Europe may also receive vaccination against polio.

In the autumn of 1965 the Ministry of Health gave permission for routine poliomyelitis vaccine to be administered at the same time as the "triple" immunisation and most medical officers have taken advantage of this. It reduces the number of the visits of the child to the clinic for these procedures by 3, and mothers much appreciate this. However, it means that the polio vaccination is commenced at an earlier age than before and the baby's response to the vaccination may be slightly less effective. To compensate for this possible deficiency, a booster poliomyelitis vaccination is therefore offered at 18 months, as well as on school entry, in order to ensure a satisfactory response.

Smallpox

Smallpox vaccination should be carried out preferably sometime during the second year of life. Supplies of lymph vaccine can be obtained from the County Health Department (Telephone 77977; Extension 514).

International certificates of vaccination (issued by the Ministry of Health), required before visitors are admitted to certain overseas countries, are submitted to the local district medical officer of health for the purpose of authenticating the doctor's signature.

Measles

Measles vaccine became available during 1968 and immunisation was offered to children over 3 and under 8 years of age who had not had measles, and to susceptible children attending day nurseries, nursery schools and residential establishments aged over one year.

In March, 1969, it was necessary to suspend the use of one type of measles vaccine and this restricted the immunisation programme. Additional supplies of vaccine became available at the end of the year.

B.C.G. Vaccination

B.C.G. Vaccination is offered to school children of over 11 years of age, and also young adults attending colleges, technical schools, etc. Parents have the opportunity of giving their consent to this procedure and the vaccination is carried out by specially trained medical officers.

Record Cards

Special personal record cards are issued to mothers attending welfare centres, and supplies are available to general practitioners on request. The importance of having these cards completed after each injection is stressed to the parents, who are also advised to produce it whenever a child attends a doctor or hospital following an accident. If the doctor has evidence of a satisfactory primary course of tetanus immunisation he will be able, under such circumstances, to give a booster dose of tetanus toxoid rather than A.T.S., and thus avoid the danger of serum sensitization.

Phenylketonuria

The phenistix test has been replaced by the more sensitive heel prick blood test (Guthrie). This new test got off to a rather slow start but by the end of the year was in full swing. Nearly all parents accept this new and improved test. During 1969 one child was found to be positive and appears to be responding well to treatment.

Congenital Defects

These continue to be notified to the Registrar General's Office and every effort is made to ensure that details are complete and accurate on the discharge forms prepared at the end of each puerperium. This is necessary not only for the Registrar General's Research Project but also as a basis on which the Health Department prepares the observation and handicap registers which are maintained for any given child throughout pre-school and school life.

Child Health Clinics

These have been reduced to 63 since Torbay became a separate authority. 1969 saw a considerable increase in developmental assessment work and this was also associated with a small increase in the number of G.P.s interested in and prepared to undertake this work.

No. purpose built	26
No. adapted and in fulltime use	10
No. used on sessional basis	27

B. Pre-School Children

Dental Care

At national level, available evidence suggests that too little time is allocated to the regular inspection and treatment of pre-school children. This also pertains in Devon, especially in rural areas. The broad picture shows many children

reaching school age without having seen a dentist, and on entering school their introduction to dentistry is often by the calamitous route of having, of necessity, extractions done in their first ever course of treatment. To overcome the problem, parents must be convinced of the need to seek routine dentistry for their young children from the age of 3.

This message is conveyed to parents at ante-natal classes, by Dental Officers attending child health clinic sessions, and since 1969, by a pilot scheme of dental inspection sessions at some playgroups, and by a reminder to parents on the school consent form that pre-school children must be seen regularly by a dentist. A glimmer of hope emerges from experience of 1969, when more pre-school children than ever before were examined (1,837), and the treatment bias was heavily weighted in favour of conserving teeth rather than extraction. Despite this improvement, the County Dental Service examines only one in seven of the pre-school population, and it is hoped that the current campaign to enlighten parents about their responsibility to young children will have more effect next year.

Playgroups, Nurseries and Child Minders

1968 and 1969 have been eventful years in the history of Nurseries and Child Minders in Devon. New developments have taken place and as a result the needs of the pre-school child are far better understood by a large number of Devon mothers.

Although the statutory responsibility for the registration of nurseries and child minders still lies with the Health Department much of the progress has been achieved as a result of co-operation with other local authority departments, other organisations and the great enthusiasm of Devon playgroup staff. As before, the majority of registrations have been sought in order to form playgroups.

Formation of the Devon Pre-school Playgroup Association

This association, the D.P.P.A., was formed with massive support at the end of March 1968 and has continued to flourish. It has done a great deal to encourage interest in the needs of the pre-school child and to raise standards in playgroups.

Working party on playgroup training

In 1966 and 1967 the first courses for playgroup staff were held in Devon. As very little had been done elsewhere in the country those of us concerned felt that they were experimental. We realised that there was room for improvement, so in Spring 1968 a working party was set up to discuss further training programmes.

The members of the working party consisted of representatives from the Health and Education Departments of the local authorities in the area, principals of the local Technical Colleges and members of the D.P.P.A.

Plans were made for courses to start in Autumn 1968 and it was agreed that the content of the courses must continue to be reviewed and that the playgroup staff who attended should be asked to offer constructive criticism at the end of each course. There would be regular consultation between Health and Education Departments and the D.P.P.A. so that, if necessary, the content of the courses could be changed.

Three of the local Technical Colleges agreed to hold courses and Devon Education Department agreed to run courses in different centres as required—where necessary taking the courses to the more remote areas.

The following list illustrates how much was done in the four terms that followed.

Courses held Autumn 1968—Autumn 1969

Commencing Autumn Term 1968

North Devon Technical College
Exeter Technical College (three term course)
South Devon Technical College
Exmouth
Tavistock
Holsworthy

Commencing Spring Term 1969

Exeter Technical College (two term course)
South Devon Technical College (two basic courses)
Dartington

Commencing Summer Term 1969

South Molton
Hartland
South Devon Technical College—one basic course
one intermediate course

Honiton

Autumn 1969

Newton Abbot
South Devon Technical College (intermediate course)
Exmouth
Bideford
Winkleigh
Honiton
Holsworthy
Ilfracombe
Tavistock
Yealmpton

The courses consisted of from eight to 30 sessions and were each attended by from 14 to 40 students. During these four terms approximately 600 Devon people, mostly women, received a basic training in playgroup work and the needs of the pre-school child.

Although most of the students were playgroups staff, some had not yet started playgroups and others attended because they believed that they would be helped in their role as mothers.

With few exceptions students have found that these courses have helped them to be better playgroup staff and more understanding mothers. Having attended one course most students feel they would like to attend a more advanced course.

The D.P.P.A. has also held useful meetings and short courses have been arranged on specialised aspects of playgroup work, for example a residential weekend course organised jointly by the Health Department and the Spastics Society was held at Dartington Hall in October 1969. It was called "The Different Child" and dealt with children with handicaps or characteristics of different kinds, one lecture being devoted to the gifted child.

The Health Services and Public Health Act, 1968

This came into force on 1st November, 1968, and contained amendments to the 1948 Nurseries and Child Minders Regulations Act.

Under the new act child minders of only one child had to register whereas previously a child minder was only required to register if she took three or more children.

Local authorities were given more powers in respect of nurseries and child minders. Although the new act laid down requirements in fairly broad terms, the Ministry of Health issued to local health authorities suggestions for detailed standards. These have been adopted in Devon.

The new act had the effect of giving local health authorities more responsibility and also of helping to raise standards considerably.

In Devon there were two main changes as a result of the new legislation. The visits to prospective child minders of up to three children were now taken over by group advisers. A medical officer continued to be responsible for the original visits to child minders of more than three children and also to day nurseries. Child minders and playgroups are visited at least once a term by the health visitor.

It was agreed that in future a person could only be in charge of a playgroup session if she was a nursery or infant teacher, a nursery nurse, or someone who had attended a course for playgroup staff which had been approved by the Health Department.

Appointment of D.P.P.A. organiser

The D.P.P.A. were given a grant by a voluntary organisation which enabled them to appoint a playgroup organiser, Mrs. Rachel Holdsworth, for 1969. She did valuable work in close-co operation with the local authority. When it was found that the voluntary organisation was unable to renew the grant for the following year the Devon Education Department, at the end of 1969, offered to make a grant available for the following year to enable Mrs. Holdsworth to continue her work.

Financial help to encourage the playgroup movement

(1) Grants

The Education Department in 1969 gave grants to playgroups which had helped with playgroup staff training, those who had accepted secondary school children as part of their home economics training and some newly formed groups.

(2) Equipment

An arrangement was made through the D.P.P.A. and county supplies whereby voluntary playgroups could buy certain items of equipment at discount.

(3) Visual aids

The Health Department made some money available for playgroup courses. This was used largely to make visual aids for courses. A very good collection of slides is now available and work was started on a film about playgroups.

(4) Handicapped children

Various methods were found of paying the fees for handicapped children who attended playgroups. Mentally, physically and socially handicapped children can now be helped.

Trends

In these two years an increasing number of playgroups were set up with the object of “helping the pre-school child”. The playgroup that started with a view to financial gain was becoming a rarity.

It had been widely said that the playgroup catered mainly for the middle class child. This became less true as the two years progressed. A large number of children from deprived homes now attend, often at no cost to the family concerned. What started as a middle class movement has now spread to the whole community.

No child who needs a playgroup in Devon should now be without one. This is due to the combined enthusiasm of the local authority, the D.P.P.A. and the playgroups themselves.

BASILDON CHILDREN’S HOME, EXMOUTH

The number of applications for admission continued to decrease, and Basildon Children’s Home was closed in June, 1968.

SPECIAL FAMILIES

With the retirement of the deputy superintendent health visitor, Miss McGilvray, the care of special families was made a responsibility of the local health visitor and group adviser, and this has proved a satisfactory arrangement. There is, of course, overall supervision from County Hall and advice and help is given if required.

LIAISON WITH THE CHILDREN’S DEPARTMENT

We have a close liaison with the Children’s Department, which is essential as so many children are the responsibility in various ways of both departments. All medical records concerning children in foster homes are examined by medical staff and advice given where necessary.

A member of the Health Department attends all case conferences at Villa Languard Reception Centre to ensure that all necessary information is presented to the Children’s Department, and that a smooth return to the community can be made.

C. CHILDREN OF SCHOOL AGE

In 1968 and 1969 we were fortunate to have a full complement of school medical officers, (9.5) and as a result the work of the school health service was up to date.

Administration—School Health Service

The number of children on the school registers are as follows:

	1969
Primary Schools	37,116
Secondary Schools, Grammar Schools, and Comprehensive Schools	22,850
Special Schools	300
Total	60,266

Direct control of this service is vested in the school health sub-committee of the Education Committee, and we are particularly fortunate in this county in the friendly and effective liaison between Education and Health Departments.

School Medical Records

1969 was the year when at last it was possible to achieve an arrangement which had been hoped for for a number of years, namely the removal of school medical records from schools to health centres. Because of limited accommodation it was not possible to remove records to clinics and, therefore, at present some records are in schools and others not. However, there is no doubt of the benefit to the school health service where it has control of its own records. These are now available throughout the day and throughout the year, and it is possible for them to be easily referred to by medical and nursing staff.

It has been agreed that a supplementary card should be kept at schools where the full records have been withdrawn so that general information on every child can be pooled. It is hoped that all staff involved with a child, e.g. head teacher, health visitor and medical officer, education welfare officer, and educational psychologist, will contribute to building up a comprehensive report on the child in these records.

Premises for medical inspection

With a few exceptions these premises remain unsatisfactory to varying degrees. Whilst accepting that in small old village schools it is not easy, and may not be worthwhile to provide special facilities, it is unfortunate that in new schools the medical inspection room is not always available and rarely has adequate changing and waiting room facilities. Every child should be examined in complete privacy, and conversation between doctor and parent must be confidential.

School Swimming Pools

The number of pools provided by schools in the county has increased rapidly since the first pool was installed in 1959. The present number is estimated to be 150, whilst a considerable number of new pools should be in commission during the summer of 1970.

There have been a number of dramatic changes in the construction of pools and in the filtration and chlorination systems. As a result, we are rapidly reaching the point where a number of the older pools require the expenditure on them of substantial sums of money.

It is not necessary to repeat the remarks which have been made in previous Annual Reports regarding correct pool maintenance, as these are now incorporated in a ten-page booklet issued to all head teachers, in which there is a very full description of the necessary methods to be adopted.

Health Visitor and School Nurse

In the school health service the health visitor is responsible for seeing that school medical inspections, testing of vision and hearing, and hygiene surveys are carried out. She is available to discuss with teachers the background of children who present a problem. Clinic nurses give assistance to the health visitors in the schools.

With the advent of very large comprehensive schools the need for increased nursing time at these schools became apparent and in 1969 a pilot scheme of attaching a school nurse to one such school was introduced. It was possible to offer only part-time attendance, but even this is of value to the school.

Apart from hygiene inspections and first aid, the nurse is able to undertake simple health education and counselling on medical matters. It is hoped that this scheme will be extended to other comprehensive schools.

Health education is an important part of the health visitor's work and over the years she has steadily increased the amount of work in this field. Many schools ask her to advise or participate in programmes and youth clubs and other organisations request talks on a number of subjects. Students from hospitals, health visitor training schools, universities and teacher training colleges accompany health visitors for varying periods for observation and practical work.

Foot Health Education—Chiropody

Many of the foot disorders met with in later life are a result of lack of care of the feet during childhood. There is no doubt that standards of footwear have improved greatly, but it is disturbing that in this affluent age shoes are still purchased at bazaars and jumble sales. No one would think of wearing second-hand spectacles, and no one should contemplate wearing secondhand shoes.

Dental Health Education

The dental hygienist, Miss Turnage, has continued her visits to junior and infant schools for dental health education, and her tour of these schools now takes two years, owing to the demand on her services from other groups. Her sessions at ante-natal classes, for example, have increased from 25 in 1966 to 63 in 1969 and similar increases in sessions for playgroups and various adult organisations have prevented a reduction of the interval between her visits to schools. An annual visit to each school must be the aim, and the question of additional staff for this purpose is currently under review.

A new impetus was given to reaching parent teacher associations and other adult audiences in 1969, in order to promote a greater awareness in parents of their responsibility to preserve the dental health of their children. Dental officers made the initial approach to head teachers at the time of the school dental inspection and in all, 51 evening sessions were spent by the Chief Dental Officer or the dental hygienist in film show/discussion groups with parents. The interest shown by parents at these sessions is rewarding, and every opportunity will be taken to continue to reach parents in this way.

An innovation in 1969 was a pilot "apples for schools" scheme which served part of the county and was designed to encourage apple eating in schools in preference to sweets and biscuits. The apples were supplied by a wholesale fruit contractor for resale in schools, with resultant profits being devoted to school funds. While results of the scheme are still being analysed sufficient enthusiasm has been shown by schools who participated to warrant a wider scheme being operated next year.

Periodic medical inspections

More emphasis and time is being given to the school entrant, and increasingly the selective form of examination is being used for the intermediate pupil.

The number of children classified "unsatisfactory" will depend very much on the medical officer doing the examination. Standards may differ, and therefore these figures do not give a reliable guide to the standard of health of the children examined.

PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By year of birth) (1)	No. of Pupils Inspected No. (2)	Physical Condition of Pupils Inspected	
		Satisfactory No. (3)	Unsatisfactory No. (4)
1965 and later	25	25	—
1964	3,571	3,567	4
1963	2,204	2,201	3
1962	647	645	2
1961	2,112	2,108	4
1960	1,622	1,618	4
1959	643	640	3
1958	1,251	1,250	1
1957	1,734	1,731	3
1956	629	628	1
1955	887	885	2
1954 and earlier	3,337	3,335	2
Totals	18,662	18,633	29

Other inspections

Number of special inspections ..	..	..	..	..	436
Number of re-inspections ..	..	..	..	..	2,305
Total					2,741

Pupils found to require treatment at periodic medical inspections (excluding dental diseases and infestation with vermin).

Notes: Pupils found at periodic inspections to require treatment for a defect are not excluded from Table C by reason of the fact that they were already under treatment for that defect. Table C relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the sum of columns (2) and (3).

PUPILS REQUIRING TREATMENT

Age Groups Inspected (By year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1965 and later	—	1	1
1964	80	312	288
1963	59	196	207
1962	24	82	78
1961	80	171	201
1960	53	152	153
1959	22	52	65
1958	59	76	114
1957	77	139	183
1956	25	51	67
1955	49	55	92
1954 and earlier	160	197	328
Total	688	1,484	1,777

Return of Defects by Medical Inspection in the year ended 31st December, 1969.

Note: All defects notes at medical inspection as requiring treatment are included in this return, whether or not this treatment was begun before the date of inspection.

RESULTS OF ROUTINE AND SPECIAL MEDICAL EXAMINATIONS

Defect Code No.	Defect or Disease	Periodic Inspections		Special Inspections	
		No. of defects		No. of defects	
		Requiring treatment	Requiring to be kept under observation but not requiring treatment	Requiring treatment	Requiring to be kept under observation but not requiring treatment
	(1)	(2)	(3)	(4)	(5)
4	Skin	231	462	9	11
5	Eyes—(a) Vision	688	436	36	9
	(b) Squint	222	130	6	3
	(c) Other	27	96	1	1
6	Ears—(a) Hearing.. ..	57	725	2	35
	(b) Otitis Media	45	437	3	4
	(c) Other	26	33	1	1
7	Nose or Throat	109	908	5	31
8	Speech	79	352	5	15
9	Lymphatic Glands	23	263	—	18
10	Heart	19	137	1	8
11	Lungs	84	403	11	15
12	Developmental—				
	(a) Hernia	20	48	1	2
	(b) Other	73	243	5	11
13	Orthopaedic—				
	(a) Posture	24	164	2	2
	(b) Feet	138	376	13	11
	(c) Other	70	297	4	5
14	Nervous system—				
	(a) Epilepsy	37	47	2	2
	(b) Other	18	111	1	4
15	Psychological—				
	(a) Development	16	273	4	19
	(b) Stability	38	500	4	8
16	Abdomen	15	92	4	1
17	Other	113	239	10	10

Infestation with vermin (head-lice)

As is our usual arrangement, neither cleansing notices nor cleansing orders were issued during 1968 nor 1969. Most of the schools in the county remained free of infestation. There are, however, a few areas which are well known to the nursing staff as requiring regular supervision. Unfortunately, towards the end of 1969 there has been some increase in the number of schools infested, and there has been some difficulty in satisfactorily treating these cases. Great credit is due to the school nurses concerned for their vigilance and persistence with treatment.

Infestation with Vermin

- /i) Total number of examinations in the schools by the school nurses or other authorised persons

42,696
- (ii) Total number of individual pupils found to be infested

127

Chiropody

In 1969 the County Chiropodist was able to offer some time for routine inspection of school children for cases of verruca and athlete's foot. At present, children with these conditions are not allowed to undertake barefoot exercises or to go swimming, but in 1970 it is hoped that a controlled trial can be carried out to see whether these measures are really useful.

CHILD GUIDANCE

We were very happy to welcome Dr. Johnston, child psychiatrist, back to the West Devon area, and also Dr. Dunn, who is child psychiatrist for South Devon.

Devon children attend child guidance clinics at Exeter, Barnstaple, Torbay and Plymouth. In the West Devon area we have been attempting to offer a more comprehensive child guidance service, which includes home visits by psychiatric social workers, but it has not been possible for the Plymouth authority to offer this. It is hoped, therefore, that in the future it may be possible to undertake much of the child guidance for West Devon from the health centre at Ivybridge.

The service has continued smoothly throughout the year with close liaison between the psychiatrists, educational psychologists, social workers and local authority staff.

We are especially fortunate in this area in that we are able to make use of the in-patient facilities for disturbed children at the Wonford Unit of Exe Vale Hospital, one of the very few such units in the country.

In 1969 a survey was made of the numbers of children in the county who could be considered autistic. Undoubtedly, there is considerable variation in the criteria for diagnosing this condition, and it would seem that the number of such children in the county is few and most of these are suitably placed in schools or junior training centres. Only two such children are in residential hospital care.

Dr. Jackson, psychiatrist in North Devon, has started a small experimental group for autistic children at the Abbeyfield junior training centre, and it is hoped that a similar group may be established in South-West Devon in the near future.

HEARING ASSESSMENT CLINICS

With the addition of a clinic at Ivybridge health centre, we now have five hearing assessment clinics in the county. Those areas which have a purpose-built sound-treated room are at a great advantage, but with the development of health centres in which it is hoped a sound-treated room will always be incorporated this problem should gradually be resolved.

We are grateful for the very close and friendly liaison offered by E.N.T. consultants and the peripatetic teachers of the partially hearing, and for the help of the audiometricians. This is essential for good results.

AUDIOMETRY

In 1969 it was decided to change from the vocabulary tests for hearing of school children to audiometric "sweep" testing. It was not possible for our three audiometricians to undertake this work unaided and, therefore, a number of school nurses were given a short course of training. The screening test is undertaken in the child's first school year, and we have not had difficulties in getting the child's co-operation. We had feared that we would be inundated with cases to be seen at the hearing assessment clinic, but, in fact, a second

screening by the school nurse and a full audiogram by the audiometrician in cases of doubt have reduced the numbers of children who fail the test to manageable proportions.

Hearing tests for infants are carried out routinely on all children according to the methods recommended by Manchester University: health visitors do this before the first birthday. An ideal arrangement would be for two health visitors to undertake this test in all cases, but in a rural area this is not possible, and any child about whom the health visitor is not happy can be re-tested at a clinic where two health visitors are available.

SPEECH THERAPY

The demand for this service increases annually, and is especially needed for pre-school children. We are now up to establishment of six full-time speech therapists and plan to increase this to seven in 1970; even then it is not possible to offer help to all the children who require it, and special groups such as the educationally or severely subnormal children have only limited help.

During the past twelve months one of the speech therapists has published three books of rhymes for use with the children in her clinics. These are also proving useful to parents and some playgroups and primary schools.

One of the senior speech therapists has taken a particular interest in non-speaking children being admitted to a normal school and so integrating with normal children. She has worked very closely with one school where the teacher concerned has made regular recordings which are being used for the child's progressive educational, language and social development. This has so far proved to be very profitable and is still evolving.

All full time therapists continue to work with adult patients in their specific areas.

Regular meetings continue to be held where all speech therapists in the County meet to discuss problems and new projects in their work. On each occasion an outside speaker has been invited, and subjects covered have included work of a psychiatrist in a child guidance clinic particularly in relation to children with speech defects or non-speaking children, and research into language problems of mongol children: this was particularly interesting as the paper on which the talk was based had been written by an educational psychologist from the University in conjunction with one of the County speech therapists.

Any conferences attended are reported on at one of these meetings so that all may benefit from experience and knowledge gained: topics have included developmental disorders of communication and work done at a London general hospital by the geriatric team. Visits to places of interest are sometimes arranged and one of these was to the Spastic Centre where a demonstration by the physiotherapist showed the latest method of dealing with cerebral palsies.

SCHOOL OPHTHALMIC SERVICE

This service has proceeded smoothly throughout the year. Health centres offer much better facilities for the testing of children's eyesight than the schools, and are being used increasingly.

HANDICAPPED CHILDREN

In 1967, following the circular from the Department of Education and Science (9/66 Co-ordination of Education, Health and Welfare Services for Handicapped Children and Young People), we considered carefully how our services to handicapped children could be improved. The Child Health Section

undertakes responsibility for these children at the age of two, and in nearly all cases a decision has by that time been made as to whether a child is handicapped or needs to remain on the “at risk” register. Few children are passed to the Child Health Section as still being “at risk”. A handicapped register is maintained in County Hall, and a duplicate kept in each area. During the years from two to five these children are under close supervision by the health visitor and medical officer and the great increase in developmental paediatric clinics has resulted in more handicapped children being diagnosed during this time. The health visitors forward their records concerning these children to County Hall for examination by the senior medical officer. Increasing numbers of handicapped children have attended local playgroups, attendance and transport where necessary being paid for by the education authority. This has proved of immense value to the children, especially the hearing handicapped, and only the limitation of funds has prevented placement of many more children.

With the formation of a nursery class attached to Exmouth Littleham Infant School, three children with problems of speech and language have been able to benefit from nursery education.

Six months before a child reaches school age, the local medical officer is asked to give his opinion concerning future educational needs, so that suitable education can be arranged before the child becomes five years old. Throughout their schooldays these children are under close surveillance.

All cases of children who are recommended for ascertainment as educationally or severely subnormal are discussed between the adviser for special education and the senior medical officer for child health and an agreed recommendation is given to the Chief Education Officer. Those children who have to attend boarding schools are visited by the medical officers during the summer holidays each year and a report is submitted; this is considered by the senior medical officer with the adviser for special education in conjunction with the report from the school, and any necessary action taken.

At junior training centres, E.S.N. schools and hearing assessment clinics, all children coming up to school-leaving age are considered by an assessment panel to plan the child’s future and ensure that suitable employment or occupation is arranged. Staff of the Adult Health Section attend E.S.N. and S.S.N. school-leavers’ panels and staff of the Welfare Department at the hearing assessment panels. Local medical officers also ensure that careful thought is given to the future of physically handicapped children attending normal schools and, if necessary, local co-ordinating meetings are held.

The number of handicapped children registered in the department at 31st December, 1969, was 1,184 children of school age and 336 aged two to five years. They fall into the following categories:

	5-to-16	2-to-5
Blind	11	—
Partially Sighted	27	4
Deaf	22	12
Partially Hearing	55	4
Epileptic	43	17
Delicate	118	85
Physically Handicapped	116	148
Educationally Subnormal	452	—
Maladjusted	69	1
Speech Defects	10	1
Mentally Handicapped (unsuitable for education at school)		
Subnormal	206	64
Severely Subnormal	55	—

Partially Hearing and Deaf Children

Severely deaf children are educated at the Royal School for the Deaf in Exeter, which has a nursery group. The children are therefore able to have help in the pre-school years, which is of such immense importance for the deaf. The School for the Deaf also has a partially hearing section, and we in the county have a partially hearing unit attached to a primary school in Barnstaple. It is hoped that a further unit will be established in the Dartington area in 1970.

However, the great majority of children with a hearing defect manage in normal schools with the help of the peripatetic teachers of the partially hearing. They regularly attend the hearing assessment clinics.

Delicate and Physically Handicapped Children

Our policy is that, wherever possible, these children should attend normal schools. In this county we find that each year we have to place two or three children with spina bifida in suitable schools, and a number of these have been able to cope in normal school.

The demand for placement at boarding schools for the physically handicapped is slowly declining.

In 1969 the Exeter and Torbay Spastics Society opened a school and treatment centre for children aged 2–9 years at Vranck House in Exeter. This has proved of great value in the treatment and education of not only cerebral palsied children but also spina bifida and muscular dystrophy cases. In addition to the children attending the school, a great number of children who attend normal schools visit the treatment centre for physiotherapy and advice concerning their handicap.

The Woodlands School, Plymouth, can now accept physically handicapped children as boarders, and this has proved valuable especially in the case of children of below average intelligence, who have been welcome there. This is in contrast to Dame Hannah Rogers School, Ivybridge, where only a small proportion of E.S.N. children are accepted.

Educationally Subnormal Children

In 1968 and 1969 we were unable to place in schools for the educationally subnormal all the children recommended for, and whose parents agreed to, such placement. There is an increasing reluctance amongst parents to allow their children to attend a residential school, especially in the younger years when special education is so valuable. Pressure on places at day E.S.N. schools may be less in 1970 with the development of further classes at Southbrook School, Exeter, but it would seem that the policy for the future should be increasingly to develop special classes for E.S.N. pupils attached to normal local schools.

A number of younger E.S.N. children may attend a junior training centre on an informal basis for a short period and then transfer to an E.S.N. school. The new Lampard-Vachell School in Barnstaple for E.S.N. pupils has a diagnostic unit for children from the age of five, and this is the ideal placement for children with learning handicaps and those who are difficult to assess in the short term. Undoubtedly, E.S.N. schools in the future will have to cater for children with multiple handicaps, and this is something which will need to be borne in mind when designing and staffing the school. There is a tendency still for the staff of special schools to be reluctant to accept children with a second handicap, and this difficulty, though understandable, must be overcome.

Epileptic Children

The modern treatment of epilepsy means that few children have “grand mal” attacks in school, and they are therefore able to remain in the normal school environment. A small number have to attend special schools for epileptic children.

Maladjusted Children

The education authority provides hostels for maladjusted children at Totnes and Willand from which the children can attend normal schools. We are fortunate in being able to place the more seriously disturbed boys in residential schools for maladjusted children within the county, but placement for girls can be a considerable problem.

Non-communicating/Auditory Imperceptive Children

A small number of children are not deaf, mentally handicapped nor autistic, yet are unable to acquire speech and language, and their education has proved a problem in recent years. These children are scattered geographically throughout the county, and only if they were residential would it be possible to educate and treat them in one unit.

It is hoped that in 1970 a unit can be established with Exeter City Education Authority for children living within a reasonable distance of Exeter, and that a special teacher will be appointed to advise in the education of those who are further afield. These children need a great deal of help from paediatricians, speech therapists and peripatetic teachers for the partially hearing, and as yet no satisfactory solution to the problem of their education has been arrived at.

Mentally Handicapped Children

With the formation of Torbay County Borough in April, 1968, the county lost control of the Mayfield junior training centre with its attached special care unit. However, county children living on the borders of Torbay are still able to attend this centre.

The numbers of children requiring places at junior training centres continues to increase. Part of this increase is due to a continued influx of mentally handicapped children into the county. The present position with regard to placement at junior training centres is as follows:

			Day Pupil Places	Residential Places
*Abbeyfield, Abbey Road, Barnstaple	..	..	55	21
*Oaklands Park, Dawlish	..	..	48	36
*Downham, Horn Lane, Plymstock	..	..	64	17
Mayfield J.T.C., Torquay Road, Paignton	..	..	21	—
Ellen Tinkham J.T.C., Exeter	..	..	11	—
Junior Training Centre, Taunton, Somerset	..	..	—	1
Bridport J.T.C., Dorset	..	..	2	—
Trengweath Centre for Spastics, Plymouth	..	..	2	1

* Devon County Council establishments.

In East Devon we are having considerable difficulty in placing children at a junior training centre when they are five, especially if the parents will not allow their child to board. It had been hoped that with the building of the Courtenay School at Stoke Lyne Hospital, and the extensions to the Exeter junior training centre, that sufficient places would be available, but this has not proved the case. A new junior training centre is planned for the financial year 1971–72 in East Devon. It is hoped that this will be sited at Honiton and will include a special care unit and day places for 60 children.

Many of the children attending junior training centres are placed there on an informal basis. A number of children who in the past have been ascertained as severely subnormal (or who have attended the junior training centres informally) have been able to transfer to a school for E.S.N. children at a later date.

We have a small sum of money available to pay for children to attend play-groups if they are unable to attend a junior training centre, and this has proved valuable.

Staff

The staff/pupil ratio in training centres remains at 1:12 children.

During 1969 it was agreed that a second infant helper should be placed at each county junior training centre to help with the junior class. This had proved necessary because of pressure of places within the reception class—existing children who were not content having to be moved out into the junior class.

It was also agreed in 1969 that each head teacher at a junior training centre should have clerical help. Head teachers were spending an increasing amount of time on administrative work—thus spending less valuable time with the children. Although the amount of clerical time offered is small, it is proving a great help to those head teachers who already have this.

The policy of the county has remained to increase the proportion of teachers who have undertaken a training course.

A second weekend course for all staff was held at Abbeyfield in 1968, and once again proved very successful. In 1969 a parents' study day was held at Abbeyfield. This was an experimental venture which was much appreciated, and it is hoped to hold further study days in other centres in the future.

Liaison with the Education Department

We are fortunate in that the special advisers for education in the authority are most helpful to the junior training centres, and each centre can call freely on the help and advice of an educational psychologist.

Health

The general health of the children in the junior training centres has been extremely good. The children are seen regularly by school medical officers and health visitors and contact is maintained with parents of children attending the centres.

Physical Education

All three junior training centres now have a covered swimming pool provided by the local Parent Teachers' Association, and there is no doubt of the great benefit which these pools offer to the children in confidence, enjoyment and physical well-being. The Devon County Group of Societies for the Mentally Handicapped holds an annual sports day in Exeter to which teams were sent from each junior training centre. This proved of great interest and enjoyment to the children, and we thank the Society for its effort on behalf of the children.

The Curriculum

We are increasingly surprised to find how much the children at junior training centres are able to learn, and the number of the older children who are able to cope with simple reading, writing and arithmetic. Our main object

is, of course, to encourage independence and social training, but even limited success with the three "Rs" does encourage the children and their parents.

Escorts

We provide escorts for about half the cars carrying children to the junior training centres, and it has not been necessary to increase this proportion.

SCHOOL DENTAL SERVICE

With the transfer of staff to the new Torbay authority in 1968, the establishment of dental officers in the county was reduced to 16. Sickness and staff changes produced effective staffing figures of 15 in 1968 and 15.3 in 1969, but a nearly full staffing position has been the pattern. This situation is welcome since it offers the essential foundation on which is built the all important relationship between operator and child patient. To a satisfactory staffing position can be added the advantages derived from new equipment and premises. New health centres, each incorporating a fully equipped dental suite, were opened at Cullompton, South Molton, Sidmouth and Holsworthy, and two new mobile clinics were brought into service, enlarging the fleet to 12. Such purpose built accommodation, fixed and mobile, is essential for efficient, comprehensive cover of our patients, and these additional facilities have already proved of great value and have drawn favourable comment from patients, parents and staff. It is no longer necessary to use portable equipment in schools, but some areas still require better clinical facilities to raise standards to an acceptable uniform level throughout the county.

While offering inspection and treatment to expectant and nursing mothers and to mentally handicapped adults, the county dental service is mainly directed to meeting the dental needs of children.

The most encouraging feature in the county dental service over the past two years has been the very considerable improvement in the comprehensive dental care of school children. Many factors contributed to this improvement including reorganisation of clinical routines, new accommodation, mobile clinics replacing portable equipment in schools, wider employment of medical anaesthetists and the delegation of more orthodontic treatment to the County Orthodontist. By far the most notable contribution however, came from dental officers in a sustained and conscious effort to provide a more efficient and more frequent service to their patients, both individually and collectively.

Statistical returns for 1968 and 1969 are given in Appendix ~~D~~^H and these indicate conclusively the advantage of regular inspections and treatment. In 1969, nearly 100% of the school population was examined and the number who were re-inspected in the year (16,079) was more than double that in any previous year. The number of teeth filled (39,095) was the highest total ever recorded in Devon, and the number of teeth extracted for caries (6,006) the lowest, when compared with any previous year. In the field of orthodontics, there was a smaller but still significant increase in the volume of treatment provided and in the number of children whose overcrowding problems were resolved.

The accent, therefore, has been on saving teeth, both permanent and deciduous. More frequent routine dental examinations is the forerunner of any pronounced emphasis on conserving teeth, and the inspection figures of the past two years represent satisfactory progress towards the ultimate goal of every child receiving six-monthly inspection, followed by treatment where necessary. This goal would be unattainable were it not for the assistance of many general dental practitioners who treat children willingly and well. It remains significant, however, that despite Devon's relatively good position compared with other

parts of the country, in terms of numbers of dentists to total population, it has not been possible for the county dental service to examine every child twice a year and to treat those who consent. With a school population which increases by nearly 2,000 each year, a review of the present staffing position will shortly become necessary if adequate coverage of Devon's school children is to be maintained.

Regular visits by dental officers, at least twice a year, to the junior centres in Barnstaple and Dawlish has been maintained over the past two years. Mobile dental clinics are taken to both centres for the greater convenience of the patient, parents and teaching staff. The welcome feature of this frequent inspection and treatment routine is that these handicapped children, whose standard of oral hygiene is often difficult to maintain, have four teeth filled for every one tooth extracted. Since the wearing of dentures can present very considerable difficulties for the mentally handicapped adult, this trend towards saving the teeth of handicapped children augurs well for their future.

The county dental service enjoys the co-operation of a great many people each year. From the Hospital Service, Mr. M. Burley, consultant orthodontist, Mr. P. H. D. Lewars, Mr. P. A. Bramley and Mr. T. C. Crewe, consultant oral surgeons, gave generously of their advice and treated those patients in need of Specialist care. Dr. K. J. Powell, consultant anaesthetist, offered invaluable guidance on our anaesthetic and resuscitation procedures. We remain indebted to all for their willing and kind assistance. Other departments and sections of the county staff afforded us their co-operation and, on behalf of the dental staff, I offer sincere thanks to the teaching staff of the county, the technical staff of the Central Repair Depot and, not least of all, to the medical and clerical staff of the Health Department, both in the field and at County Hall.

PART IV

CARE OF THE HANDICAPPED ADULT

Adult Training Centres

Hostels for Mentally Handicapped Adults

Social Workers in Mental Health

Dental Care

Artificial Kidney Machines

CARE OF THE HANDICAPPED ADULT

Adult Training Centres

The health department services for those suffering from all types of handicap continue to develop. There are six full-time adult training centres and one which opens on two days per week. This latter centre is soon to be extended to full time. There is in addition a sheltered workshop which is of course full time. The adult centres contain provision both for workshop training and for specialised social training within the unit staffed by occupational therapists. Here the incoming trainees are assessed and given any necessary social and basic work habit training until they are ready to go into the industrial atmosphere of the workshop.

Four of the adult centres are purpose-built and work has begun to replace one centre in hired premises. This centre, at Kingsteignton, should be ready for occupation in the early part of 1971. Details of the centres are given in the following table.

ADULT TRAINING CENTRES

Centre	Building	Full or Part-time	No. of places provided	No. on Register	Average Daily Attendance
Phillips Adult Training Centre, Lea Combe Estate, Lyme Road, Axminster	P*	F.T.	50	29	27
Crediton Adult Training Centre, Newcombes, Belle Parade, Crediton	N.P.†	F.T.	45	49	39
Hawley Adult Training Centre, Sowden Lane, Barnstaple	P	F.T.	120	130	109
Doyle Adult Training Centre, Salterton Road, Exmouth	P	F.T.	90	83	67
Kingsbridge Adult Training Centre, D.C.C. Clinic, Fore Street, Kingsbridge	N.P.	P.T.	10	10	6
Kingsteignton Adult Training Centre, St. Columba Church Hall, Longford Lane, Kingsteignton	N.P.	F.T.	80	97	74
Molly Owen Adult Training Centre, Pixon Lane, Westbridge, Tavistock	P	F.T.	50	53	41

*P = Purpose Built.

†N.P. = Non-Purpose Built.

East Devon Group (Exmouth, Axminster, Crediton):

The Exmouth Training Centre continues to produce a large number of paper disposable caps and gowns and this work, together with the assembly of tractor components for a local firm, provides continuity of work.

The Axminster Centre moved into its new premises on 10th March, 1969, and once again the benefits of a purpose-designed building have proved to be considerable. The framing of pictures and views has increased and this, together with the production of bag handles and paper disposable goods, provides employment for the trainees. Readers will no doubt have noted from the above table that although the centre was built to accommodate 50 persons there are only 29 on the register. The reason for this is that a hostel for mentally handicapped adults is being built on the same site and when this is completed the residents will attend the adult training centre.

The manufacture of cardboard boxes continues at the Crediton Training Centre and orders continue to increase. This centre is also involved in the production of paper disposables, the demand for which has increased so greatly that we have found it possible to sub-contract work to the Royal Western Counties Hospitals.

South West Devon Group (Kingsteignton, Kingsbridge, Tavistock):

The Kingsteignton Adult Training Centre is housed in hired premises but work has now started on a new 120-place centre and it is hoped that these premises will be ready by early 1971.

During 1968–69 there was little change in the operation of the Kingsbridge Training Centre, which continued to be held on two days per week at the clinic. However, in December 1969 we were successful in hiring a Church Hall in Kingsbridge, and in February the centre began operating on a five-day week basis.

The Tavistock Training Centre, which was previously part-time, moved into new purpose-built accommodation early in 1969 and rapidly began to consolidate their position in the polystyrene market, with a greater emphasis on the packaging side rather than domestic insulation and decoration.

Barnstaple (Hawley):

Although the manufacture of incontinence pads provides the main financial basis for this centre, we have now diversified somewhat by introducing such work as sewing and the packaging of cutlery for an airline.

SHELTERED WORKSHOP

Ivor Thomas Workshop, Barnstaple:

This centre, approved by the Department of Employment and Productivity, commenced in November 1966 in rented accommodation in Barnstaple. In November 1968 the workshop moved into new purpose-built accommodation adjacent to the Hawley Adult Training Centre and was officially opened on 4th September 1969 by the Rt. Hon. Jeremy Thorpe, M.P. The workshop provides employment for 17 disabled workers and it is hoped that this number will increase to 25 by the end of 1970.

HOSTELS FOR MENTALLY HANDICAPPED ADULTS

There are at present two hostels for the adult mentally handicapped—Ocombe House, Marldon, Paignton and Hawley House, Barnstaple. A third is being built at Axminster and will be coming into use at the end of 1970.

Each hostel has a house committee of local district and county councillors who work with the staff and local voluntary organisations for the well being of the residents. This committee is able to make recommendations to the Adult Health Sub-Committee with regard to the running and equipping of the hostels. We are most fortunate in having several organisations and societies interested in the present two hostels and much is done to help the residents both in a financial and practical way, especially during holiday times.

All residents at the hostels receive 20/- from their social security allowance, together with a small wage for either working in the hostel or at an adult training centre. On admission, the residents open a Post Office savings account and are encouraged to save for holidays and personal needs.

Occombe House, Marldon

This hostel which accommodates 11 female and 12 male residents is staffed by a warden and matron; deputy matron; a resident cook/housekeeper; and a gardener/handyman who works on a daily basis. The deputy matron lives in only when required.

Hawley House, Barnstaple

This hostel is staffed by a warden and matron; deputy warden and deputy matron; a daily cook and an assistant cook. It is attached to a 120-place adult training centre by a kitchen which serves both establishments. The warden and matron are responsible for the kitchen and the preparation of meals, not only for the residents of the hostel but also the training centre and the local "meals on wheels" service. The accommodation is for 19 adult males who live in the main building and 8 adult females who are accommodated in an annexe some thirty yards from the main building. The deputy warden and the deputy matron sleep in the main building and the warden and matron live in a newly built bungalow in the grounds.

SOCIAL WORKERS IN MENTAL HEALTH

A comprehensive community care service for all types of mentally disordered adults has been in existence for many years in the county and the field staff is 28 area social workers and one trainee social worker. The social workers are based throughout the county which for this purpose is divided into four areas with a senior area social worker in charge of each. These areas cover the catchment areas of a psychiatric hospital or of the Barnstaple and Torbay hospitals where outpatient clinics are already in existence. The senior area social workers are responsible for the day-to-day administration of the service in their particular area and co-ordinating the work of their social workers in order to provide economy of individual effort.

There are also joint appointments with Exe Vale Hospital, Exeter City and Torbay County Borough, of a Head Social Worker and three social workers, all based at Exe Vale Hospital. The Head Social Worker assists in the co-ordination of the work of the four authorities.

The active case load of each individual social worker is large and the number of social workers employed has increased annually.

Assessment panels are held at which those cases of young mentally handicapped persons who have been discharged from special schools or junior training centres are discussed with a view to arranging for future care and training as soon as possible. Medical officers, social workers, school teachers, educational psychologists, youth employment officers and workers from other agencies concerned are invited to these panels to decide what is best in the interests of the individual. Apart from employment, the Department of Employment and Productivity can offer courses at its rehabilitation units where these young persons can be taught a basic trade, or this department can offer training at our own adult training centres, or domiciliary occupational therapy outwork.

Social Work Training

The Health Committee encourages the further training of staff. Exeter University uses officers of the department as placements for its graduate students, and Moorhaven Hospital and Plymouth Technical College also use these facilities.

ties in connection with the training of social work students. The section's services as a whole are used by Exeter University and Plymouth Technical College to give their students a general insight into the working of the social services.

Further details of social work staff may be found in Appendix M. Details of hospital admissions and discharges and of waiting lists of the mentally handicapped are in Appendix O.

A SOCIAL WORKER'S VIEW OF HIS ROLE IN HOSTELS FOR THE MENTALLY HANDICAPPED

Whatever the size of the Local Authority, whether it is a County Council or a County Borough, most of the Social Workers will have had some contact with a hostel, mainly because they will have placed residents there and will be maintaining contact with them and their relatives. However, a social worker may have no "role" within the true meaning of that word within the hostel and the following illustrates the need for at least one social worker in the Local Authority to have this special role.

It is almost unbelievable to recall that hardly more than a decade ago, psychiatric hospitals were called lunatic asylums—abnormal communities separated from the normal community. This was especially so in regard to hospitals for the mentally subnormal, usually sited well away from the main community. Except for those with kin in the hospital, few knew or cared about it or its residents. This rural isolation from the main stream of community life has perhaps been the breeding ground for the unhappy environments which have evolved in some of these institutions.

Now however, owing to changed ideas, legislation and public opinion, psychiatric hospitals have come to be regarded as part of the community; and hostels too are part of the community. Just as any family with a mentally subnormal member has needs and expectations in regard to social work support, so the hostel family has needs and expectations for similar support. The hostel family may not be a problem family as such, but it does have complexities which require special attention.

For this reason, the social worker's role must never be superficial, must never be a "popping in when passing" role; neither should the social worker be an "authority figure" occasionally appearing, whom staff use to subdue unruly residents, nor an over-sympathetic, resident-biased social worker whom aggrieved residents can use against the staff. Not only should he have a real work role but also a real work goal. What this is will depend on the particular function of the hostel, upon whether it is primarily a permanent home for all its residents or has a rehabilitative function. Devon's hostels have the dual function.

The following is an example of one hostel in the County which was founded 4½ years ago to accommodate 23 residents—12 males and 11 females. Ten of the original 23 still live at the hostel. During the 4½ years, 32 residents have been discharged; 13 of these were admittedly short stay requiring either a holiday or emergency accommodation. Seven were discharged to hospitals, 3 suffering from psychosis, one from a severe physical illness and 3 were discharged to hospitals for the subnormal. Five were taken home by parents who previously thought they could not live or cope with them but subsequently found they could not live without them—and we should not criticise such parents, because the hostel is being used effectively when it clarifies emotional problems of this kind. Seven residents left of their own accord to live in lodgings they had found for themselves. Only one failed and she had to be admitted to a hospital for the subnormal. Ten residents were rehabilitated in the sense that they came to the

hostel, unable to live elsewhere, unable to undertake normal employment, and left able to do both.

Currently, among the ten for whom the hostel is not regarded as a permanent home, 4 are in normal employment, 4 work at the County Council's Workshops and 2 work in the hostel. Experience has shown that those who live in the hostel move more swiftly into normal employment. Two of the four in normal employment could be discharged immediately, and will be when a suitable home can be found for them. Two others could be immediately discharged to their own homes and are likely to be so because the problems and pressures which faced them when admitted to the hostel no longer exist. From all this it may be seen that the 13 beds have been used to accommodate 32 residents during a $4\frac{1}{2}$ year period, with only 3 discharged to hospitals for the subnormal and 10 residents rehabilitated in the true sense.

An active programme is in operation whereby social workers undertake group therapy with patients on the wards of psychiatric hospitals. Consequently they have knowledge of patients in the hospital who have potential for rehabilitation, using the hostel as a halfway house. Whenever a hostel resident goes on holiday, even for a week-end, the vacancy is used to accommodate someone on the waiting list, this may be a client in the community, or a patient in hospital. In either instance, the social worker will have been undertaking case work or group therapy with them and will have passed on to the hostel staff details and comprehensive information about the potential resident. These trial periods have proved invaluable in assessing priority, suitability, special needs and approach in emotional support. It is significant that the best rehabilitation prospects have come from hospital, and without doubt in the hospitals there are scores of patients who could be accommodated in hostels.

For instance a boy who was placed in hospital at the age of 3 was promptly forgotten by his family and never visited again. I met this boy when he was 23 and institutionalised. He spoke in a slurred voice and had a withdrawn personality but had a good appearance. Eventually we transferred him to our hostel. Here he was depressed and weepy—homesick for the institution, so we let him go back for week-ends. Gradually he improved and now, two years later, is undertaking normal employment. Additionally, he goes to the "local" every night and has a pint, and is accepted by the local people as one of themselves, although they know he is a little backward. Here you have a boy who was institutionalised and as far as the community was concerned, was dead; he was brought out of the institution and is now alive, moving more and more towards maturation, working in normal employment, and leading a useful and fruitful life.

With the hostel family there are three categories of people to work with and for—the permanent resident, the temporary resident and staff. To the staff one is a colleague who can be relied upon for advice and support, although this may not always be acceptable. Every Wednesday evening staff, residents and the social worker meet for group therapy sessions. These and the discussions which follow, cement relationships more than anything else. Quite apart from visits for interviews with residents, the hostel is visited at least twice a week for informal meetings with the Warden and Matron which is helpful in enabling us to understand each other's work and problems.

The approach to residents varies, not only because no two individuals are alike, but additionally, hostel residents generally come from vastly different cultural environments: many come from families who have over-protected them and in so doing have limited capacity for social relationships. It sometimes appears that over-protection is linked with social position, with the higher income groups being more over-protected than those in the lower income groups. Environment is an important factor, for instance in populated areas play is

more informal—the streets are playgrounds and it is not at all uncommon to see a subnormal child mixing happily with others in the street, thus having an opportunity to experience social relationships which he would never have in a select residential area.

Residents who come from hospitals tend at first to be on their guard and unwilling to see the social worker other than as one of the many “authority” figures that have passed through their lives—another factor to remember in assessing need and the kind of support necessary to ensure a good adjustment to hostel life. It is important to avoid a parental approach. People often behave as they are expected to behave—in visiting many establishments one finds that the client’s impaired intellect seems to encourage some staff to adopt a parental attitude, to which the clients understandably respond by behaving like children.

Properly encouraged, many subnormal adults have the capacity to behave with reasonable maturity and when this happens their self esteem is enhanced and their lives improved. In the hospital, group meetings attended by staff, social worker and residents are helpful in dispelling the parent/child attitudes where these exist—provided the residents are made to feel that in the group setting they have the same status and freedom to comment as staff. We started group therapy in the hostel about a year ago, and the results have been most favourable. The social worker acts as group leader and group membership is limited to nine residents, mainly confined to those with rehabilitation potential.

The following brief case illustrations may show how group therapy assists residents and staff:

- (1) Twenty-one year old ‘X’ had a long history of rejection and as a result was sullen, withdrawn and untrusting; no-one could get through to him at all. In the group sessions he sat silent and morose, not participating. Gradually however he started entering into the discussions and it emerged that the main feature with him was that he trusted no-one. He admitted this during group discussions and he had good reason to trust no-one because throughout his life he had been rejected; neither did he believe anybody could ever care for him, for until he came to the hostel, no-one had cared for him—in fact, he was a hard boy to care for and when he first came to the hostel he was extremely unpleasant to get on with. When in discussion it gradually got through to him that someone did care, and the very fact we were there made this obvious to him, he became more pleasant and his real personality emerged. He has now developed into a fairly reasonable boy and is also undertaking part time employment.
- (2) ‘Y’ came to our hostel at the age of 16 after failing in other hostels and homes in the South-West. She was extremely difficult during the first two years and it did seem that we might have to ask her parents to take her away. Then we started group therapy with her, from which she benefitted extraordinarily well. Previously a rather dirty, untidy, scruffy, argumentative girl who would not bother about personal hygiene or looks, she became clean and started wearing what one might term “gear” clothes, and has now matured into a most pleasing and pretty girl.
- (3) ‘Z’ is a severely spastic girl who has walked all her life with the aid of sticks. During one group therapy session, she was sufficiently moved to make the following commitment—“I’m not going to use these sticks any more! I’m going to do without them.” Those of you who know anything about group therapy will know that a group commitment is an emotional and serious undertaking and although you will find it difficult to believe, this girl did away with those sticks. First she staggered around holding on to chairs and walls but now she gets out of taxis and walks into and about the hostel unaided—staggering a little, admittedly, but she has done away with the sticks!

Group therapy accelerates maturation, gives staff and social workers a great deal of insight into the thoughts and views of clients, and gives residents and staff an opportunity to ventilate hidden grievances—because as much as you try to hide them, the group situation will bring them out. As I have said however, group therapy is currently confined to those who are considered to have rehabilitation potential, and this excludes the severely subnormal.

Among our residents who can rightly be called severely subnormal is a 30 year old woman who has been deaf and dumb since birth. Her eye sight is so severely impaired that she can only recognise the Matron as a person when she has a white coat on. When Matron takes her white coat off, June cannot recognise her and sees her only as a blur. As the social worker it seemed that the most one could do was to make her aware of one's existence and that one cared for her. She could not hear, or speak or understand speech and could not see properly—the only way she could identify was by touch and smell. Quite recently under group therapy, discussion ranged around “what makes a good resident?” then it evolved into “who is the best or most valuable resident?” Finally, it came down to this deaf, dumb and blind girl who was declared the most valuable resident. When we asked the reason for their choice they said unanimously “You can always love her and she will never let you down.”

Social workers move in a world where love is sometimes a scarce commodity, and wherein they are constantly brought face to face with the results of insufficient love. In their work they are all too often endeavouring to help those who suffer from the effects of selfishness and lack of concern for others and in their endeavour to assist the severely subnormal they will be helped by bearing all this in mind, since it is often easy to become pessimistic—not about helping the severely subnormal but about whether the help being given and the sacrifices being made are in the long run worthwhile.

Social workers must bear in mind that whatever the severely subnormal cannot do, they can and do engender love, love which not only illuminates and enriches their own lives but the lives of all those about them. Like June they have value and one should not forget that however severe their disabilities, the severely subnormal have potential to help and be helped.

Dental Care of the Mentally Handicapped Adult

In 1969, it was possible to offer inspection and treatment at each Adult Workshop at least once in the year through the County Dental Service. The numbers inspected and the volume of treatment provided, have surpassed the figures of earlier years, and tribute must be paid to the Staff in the Workshops for encouraging Trainees to accept treatment regularly. The standards of oral hygiene in this group of patients is always below par, and regular dental examination can be most valuable in effecting improvement. For this reason alone, it is hoped to include each Workshop in a six monthly cycle of inspection and treatment, where staffing permits.

Dental inspection and treatment returns for Adult Trainees are quoted in Appendix H.

Artificial Kidney Machines

During the past year, a new service has come into being—the provision by this department of adaptations to a persons home to enable an artificial kidney to be installed.

There are now six homes, either adapted or in the process of adaptation, and it is expected that about thirty more machines will be installed during the next two years.

Depending on the various situations, the artificial kidney is placed either in an adapted room in the house, a brick or other permanent house extension, or in a portable type of building situated close to the house.

PART V

CARE OF RETIRED AND ELDERLY PERSONS

Retirement Clinics

Nursing Care

Chiropody and Laboratory Appliances

Home Help Service

Occupational Therapy

CARE OF RETIRED AND ELDERLY PERSONS

Retirement Clinics

Health visitors co-operate with consultants, family doctors, nurses and social workers in the care of the elderly. In five areas health visitors, assisted by clinic nurses, are running retirement clinics. The amount of work relating to this age group has steadily increased over the years, but much remains to be done.

By the beginning of 1968, 250 patients aged between 50 and 70 had participated in the Paignton survey, which was the joint project of Dr. J. F. Burdon of Paignton and the health department.

Each patient had been interviewed by the health visitor, many tests had been performed by a nurse, and finally each patient was examined by a local authority medical officer and Dr. Burdon.

Much detailed information had been obtained from this survey and also from the retirement clinics at Ottery St. Mary, Honiton and Tiverton, which were started the previous year.

We found by experience that some of the tests that had been done routinely were not necessary. A high proportion of the abnormal conditions that were diagnosed could have been detected by the questionnaire and by the screening tests which were performed by the nurse. Only where some of these gave abnormal results did the doctor subsequently obtain any useful additional information about the patient during the clinical examination.

It was decided to streamline the retirement clinics so that fewer questions were asked and tests done. Only where these suggested an abnormality were more detailed tests done and the patient referred to the doctor for follow-up.

Paignton became part of the new Torbay County Borough in April 1968, and it was decided at this time to end the Paignton survey. This survey had yielded very useful information and helped in the more efficient planning of our retirement clinics.

The retirement clinics continued in this streamlined form at Honiton, Ottery St. Mary and Tiverton, and new clinics started at Torrington in June 1969, Budleigh Salterton in July 1969 and Braunton in October 1969.

Patients aged 65 to 70 are invited to attend by their general practitioners. If they accept they are interviewed by the health visitor attached to the practice, and have screening tests performed by other local authority nursing staff. If an abnormality is found the patient is referred to his general practitioner.

Findings

There is no doubt that many patients have benefited from these clinics. There is also a great deal of interesting and useful statistical information as a result of the retirement clinic work which we hope, when possible, to have analysed accurately with the help of the computer. To analyse the figures manually is a very time-consuming job and it has not yet been possible to do the full analysis that this very interesting project merits.

There are, however, obvious trends which are of interest.

The acceptance rate for these clinics varies from one centre to another, between 45 and 80 per cent, and depends especially on the enthusiasm of the clinic staff and general practitioners concerned.

Of the patients screened, over 60 per cent are referred to their doctors with abnormalities. In some cases the doctor does not consider treatment to be necessary, but in many cases advice or treatment is given, sometimes for a

major condition but more often for a relatively minor condition, but one which nevertheless handicaps the patient.

Examples of the relatively minor but common conditions are corns and callosities, varicose veins, wax in the ears causing deafness and unsuitable glasses.

A few patients have been referred for surgery for treatment of urinary symptoms, especially prostate troubles in men and prolapses in women.

Smoking and Obesity

Inadequate respiratory function is found in approximately 25 per cent of the patients. Usually this occurs in smokers, and the obese are also more likely than average to be affected.

The effects of smoking are also seen in the patients with heart disease.

A high proportion of patients with arthritis are overweight.

It is hoped that the advice that is given by the health visitors, nurses and doctors on smoking and dietary habits will help these patients, but no follow-up studies have been done.

Depression is a common finding and, in widowed people, it is the exception for it to be absent. Single people in this age group, who live alone, seem to be much less at risk than those who have been married and subsequently bereaved. The health visitors discuss social problems during their interviews with patients and have in some cases been able to make suggestions which have done a great deal to alleviate loneliness.

Anaemia

Contrary to expectations anaemia has not been a common finding. We wondered at first whether patients who did not accept the invitation to attend the retirement clinic were more likely to be anaemic than those who made the effort to come. However, as far as we could tell from follow-up by the health visitor and existing medical records on these patients, this was unlikely to be a significant factor.

Of 393 men and 446 women seen at Honiton, Ottery St. Mary and Tiverton in 1968, only 5 men and 26 women had haemoglobins under 80 per cent and only 10 had haemoglobins under 70 per cent.

At the other end of the scale all 19 patients with haemoglobins of over 115 per cent had an associated abnormal medical condition.

Urinary Infections

Again, contrary to expectations, these have not been found frequently and are a new finding in less than 1 per cent of the patients examined.

Cancer

Vaginal and breast examinations are not performed at these clinics as women who have not had them recently are referred to the local authority or family doctor cervical cytology clinics. We therefore would not expect to find uterine and breast cancers, though if these are present they would be detected as a result of the referrals.

Two patients have had gastric carcinomas diagnosed during 1968 and 1969 but in each case the diagnosis was made too late for satisfactory treatment to be given.

Carcinoma of the prostate has been diagnosed with a more favourable outcome.

Other Diagnoses

A large number of other conditions requiring treatment have been newly diagnosed, each in a small number of patients. These include diabetes, glaucoma, cataract, vaginal infections, hypertension and hernia.

Value

It is very difficult to estimate how many patients will have lasting benefit from attending these clinics. However it is probable that at least 25 per cent of the patients who receive invitations will benefit to a greater or lesser degree, and that of those who attend, over 50 per cent will have some benefit.

The cost to the county per patient who attends is in the region of £2, excluding the cost of the use of the clinic and health centre premises.

When it becomes possible to embark on detailed data analysis it is probable that there will be information that will be of national interest and value.

Nursing Care

It is interesting to see that more than 75 per cent of the total of 12,681 patients attended by our district nurses were over the age of 65 years; there will be an increase in the nurses' work in this age group in the future.

To keep the elderly happily independent in their own environment we must aim to give assistance well before the skills of a trained nurse are required. With this in mind, in-service training was introduced in three areas with the idea of providing ancillary staff in the home help service. Seventy selected home helps were invited to attend these training courses, which were organised and run by the nursing officers and district nursing sisters working in the individual areas. Much value was gained from this training and the 'special duty' home helps are employed, sometimes along with their domestic duties, helping the elderly and handicapped patient. The basic work of the ancillary helper is bathing, washing, dressing and foot hygiene—work that does not require the skills of a qualified nurse. The district nurse pays the initial visit to all new patients, to assess their need. When the work is carried out by ancillary staff, the trained nurse keeps in touch with, and takes the ultimate responsibility for, the patient. Since the end of the training courses help has been given to 49 patients, with 532 visits paid by the specially trained home helps. I envisage an increasing demand in the future for this service.

Chiropody

Although this service is for four groups in the community, i.e. the handicapped, pregnant women, schoolchildren and the aged, the vast majority of patients treated are in the elderly group. It has already been mentioned that many foot troubles are a legacy of past lack of care of the feet and of course the problems of treatment is not eased by the ingrained bad habits of a lifetime, but the chiropody service is certainly appreciated by the older members of the community.

Each year greater demands are made on this service and, although progressively more chiropodists are employed, they barely keep pace with the demand. At present there are 19 full-time chiropodists employed. During the last year the total number of patients waiting for treatment at 31st December was 481. The distribution of this waiting list throughout the county is as follows:

South Devon	(85)	This area includes Dartmouth, Buckfastleigh, Ashburton, Newton Abbot, Teignmouth and Dawlish.
East Devon	(172)	This includes the area east of Tiverton and Crediton.
North Devon	(173)	This is the part of Devon north of a line drawn a little south of Holsworthy to South Molton.
West Devon	(51)	This area includes Kingsbridge, Okehampton and Tavistock.

The drop of almost 200 in the waiting list occurred mainly in the East Devon area where, at the end of 1968, the figure was 475. This was mainly due

to the employment in Sidmouth of a full-time chiropodist. In addition, for the first time in a considerable while, all chiropodists' posts were filled at the beginning of October. This state of affairs lasted for only five weeks, as one North Devon chiropodist died early in November and one from East Devon resigned at the end of that month, so that the lessening of the waiting period has temporarily been arrested until vacancies on the staff can be filled.

It was also found that with the increase in the number of health centres, with adequate chiropody clinic facilities, it became more economic from the point of view of the chiropodists' time to close some of the smaller, inadequate rural clinics, and bring patients to the new health centres, even though this meant a greater use of the hospital car service, where public transport was inadequate or, more frequently, non-existent. Hospital car journeys undertaken in 1969 numbered 9,358 as compared with 7,486 in the previous year.

This policy has been justified by the fact that although there were 74 clinics operating on 31st December, 1969, 24 less than the number operating on 31st December, 1968, there was an increase in the number of treatments to 49,628 from the previous year's total of 46,856.

The main object of the service is to keep as many elderly persons as possible mobile and fit enough to reside in their own homes, instead of allowing them to become housebound and eventually in need of residential care. The hospital car service continues to offer transport to clinics for those patients medically recommended and those who have no other possible means of transport. In many instances the service is only needed for initial treatments for patients medically recommended. After the first treatment these are able to make their own way for further treatment.

County Chiropody Clinics

	1965	1966	1967	1968	1969
Number of chiropody clinics operating ..	126	134	122	98	74
Old People's Homes or hostels visited (Welfare and Private)	21	28	29	24	25
Treatments at D.C.C. hostels for the elderly	1,851	2,615	2,907	2,653	2,878
Treatments at Registered Old People's Homes	737	611	806	667	323
Treatments to School Children	916	1,136	1,598	913	643
Treatment to adults at clinics	38,550	43,824	50,467	42,309	43,826
Domiciliary treatment visits	737	950	998	314	713
Total treatments provided	42,791	49,136	56,776	46,856	49,628
Waiting list at 31st December	762	482	862	660	481
Chiropodial appliances fitted	—	—	595	649	2,659

Laboratory Appliances

During the past two years this service has expanded considerably. In the laboratory various semi-permanent chiropody appliances are made such as insoles and shields, and new techniques are quickly adapted to ensure maximum patient comfort and efficient treatment.

During 1969 a total number of 1,115 latex digital appliances and 1,544 insoles and supports of various kinds have been made. This has had the effect of reducing the waiting lists at a number of clinics.

At the moment we are experimenting with Plastazote. It is hoped in the near future to be able to produce insoles and supports using this material, but the question of Plastazote footwear must remain in abeyance until further experiments have been successfully completed as this is causing considerable difficulty due to the lack of a vacuum forming machine.

It has been interesting to note the number of surgical insoles which have come to us for alteration from other sources. In most cases these have had to be stripped down to the cork base and remade on a cast of the patient's foot.

Home Help Service

Administration. The county organiser works from County Hall, Exeter, and is responsible for the administration of the service throughout the county, through area organisers and assistants who are based at health centres or major clinics in each of the eight areas. The W.R.V.S. continued to run the service at Dartmouth Borough. All accounts relating to the service are raised in the health department and the county organiser is responsible for their collection by full-time collectors, with the exception of one area which is controlled from the home help office at County Hall. This latter method of collection is likely to be adopted generally over the next two years.

Details of cases dealt with are set out in the tables in Appendix L.

Table 1 shows the total figures for the year 1968. At the 31st March, 1968 1,250 cases were transferred to the new Torbay County Borough. Table 2 shows the impact of these transfers. The figures in brackets in Table 2, when added together, represent the total number of cases dealt with during the whole year in the new county area.

It is interesting to note that in 1967 the number of cases dealt with exceeded those of the previous year by 159, when both statistical tables included Torbay. In 1969 (see Table 3) the number of cases (3,744) in the new county area exceeded those of 1968 by 160 (3,584)—excluding Torbay—so the actual percentage increase was considerable, and the steady increase in the demand for the service continues more or less as anticipated.

Liaison with Doctors and Hospitals. With the opening of more health centres, it has become possible to achieve an even closer liaison with general practitioners and field staff of the health department. This has resulted in a more personal contact and, in consequence, a better understanding of what is required of the service and what can be provided, and a more speedy response to requests for help.

Medical social workers in hospitals are also relying more on the service, with this possibility of immediate contact at the health centre or clinic. Officers of the Department of Health and Social Security are also referring more cases. But the striking feature of the service is that the great majority, some 90 per cent, of referrals come direct from doctors, health visitors, nurses and field staff of the health department. Enquiries addressed to the County Medical Officer are forwarded to the appropriate area organiser. In urgent cases telephoned instructions are given.

OCCUPATIONAL THERAPY

Staffing

The establishment for 1969 was one head occupational therapist, twenty-one occupational therapists and two technicians: at the end of 1969 for almost the first time we had no vacancies.

The two technicians work with the occupational therapists in the assessment and training of those less able both physically and mentally. They also supply a much needed male influence in this section. Whilst assisting in the unit the technicians undertake the manufacture of custom-made aids and gadgets for individuals. Previously, the client went without these or had to wait a very long time for them. The technician works to the therapist's specifications, and also accompanies the occupational therapist to the client's home to give advice and to fix the required aid. It is often difficult to get a builder to do small jobs quickly and by using technicians the patients' needs are more quickly met. Many aids—unobtainable elsewhere—have been produced.

Domiciliary Service

The county's domiciliary occupational therapy service has continued to be in great demand and there were over 2,500 cases on the register at 31st December. Aids to daily living and advice on structural alterations take up the greater part of the therapists' time but this work is most rewarding. It is essential that clients are taught to use the aids supplied correctly and with confidence. The therapists pay regular check visits to all clients with aids and supervise their continued maintenance. The therapists continue to visit patients with aids issued by hospitals and voluntary associations—some of these many years ago. Due to wear and tear these aids may have become dangerous. A worn rubber on a stick or crutch can let down the owner who may treat it with complete confidence. Similarly, aids issued in a hospital or clinic may not be suitable for the home. A tripod may fill the need in a physiotherapy department where the floor is level, but it could be a menace on an uneven tiled floor or a broken surfaced path.

During 1969, a survey of cases on the occupational therapy register revealed a heavy increase over the last two years of persons aged 65 years and over.

This increase is due to many factors, but primarily the increased longevity of the population as a whole, but also to the tendency of retired persons to settle in Devon, often in small, unsuitable restored cottages. As these people age they become more incapacitated and very often they lack the support of family and friends in the new environment. Previously these problems were largely confined to the coastal areas from Axminster to Torbay, but we are now encountering similar problems in other areas of the county.

One of the most encouraging factors in the increased referrals is the involvement of the general practitioner. The doctors not only make good use of the service but are prepared to welcome the occupational therapists into their surgeries for case discussions and to carry out joint visits.

PART VI

OTHER LOCAL HEALTH AUTHORITY SERVICES

Health Centres

Ambulance Service

Home Nursing and Health Visiting

Health Education

OTHER LOCAL HEALTH AUTHORITY SERVICES

Health Centres

The building programme showed particularly good results during 1968 and 1969. During this period 14 new purpose-built health centres were opened and premises for a fifteenth were purchased with a view to adaptation. Over a quarter of the general practitioners based in the county area now practise wholly or mainly from health centres and the proportion will probably reach 50 per cent within the next few years.

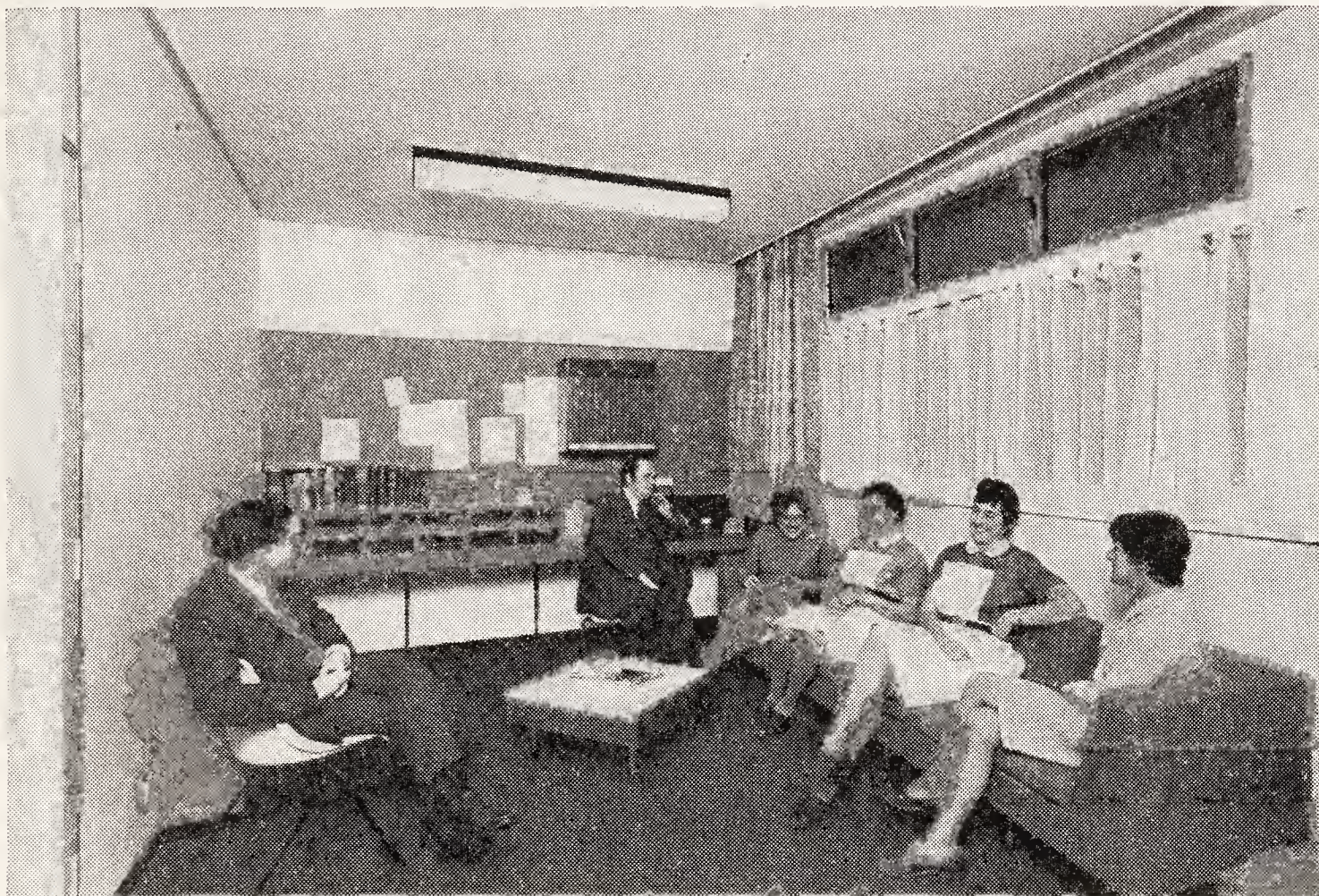
Further details of the health centres completed, under construction or planned are given below:

Completed	Year of opening	Number of practices served by Centre	Number of general practitioners using Centre	Special facilities	Centres sited near adjacent or in Cottage Hospital Grounds
Ottery St. Mary ..	1966	1	4	—	—
Budleigh Salterton ..	1966	1	3	—	—
Buckfastleigh ..	1966	1	2	—	—
Okehampton ..	1966	2	4	0	hospital grounds
Lynton	1966	1	2	—	adjacent
Ipplepen	1967	1	1	D	—
Ilfracombe	1967	2	4	—	near
Seaton	1967	1	3	—	—
Kingsteignton ..	1968	1	2	—	—
Torrington	1968	2	2	D	—
Bovey Tracey ..	1968	2	2	—	—
Colyton	1968	1	2	—	—
Ashburton	1968	1	2	D	near
Combe Martin ..	1968	1	1	—	—
South Molton ..	1968	2	4	—	near
Northam	1968	1	3	—	—
Cullompton	1968	1	4	—	—
Ivybridge	1969	2	4	—	—
Yealmpton	1969	1	2	D	—
Salcombe	1969	1	3	—	—
Sidmouth	1969	1	6	—	adjacent
Holsworthy	1969	1	4	D	—
South Brent	1969	1	1	—	—
<i>Under Construction:</i>					
Yelverton		1	3	D	—
Dawlish		2	4	—	near
Chudleigh		2	3	—	—
Chagford		1	2	—	—
Moretonhampstead ..		1	2	—	adjacent
<i>1970/71/72 Building Programme:</i>					
Bideford		3	9	—	hospital grounds
Kingsbridge		1	4	O	—
Silverton		1	2	D	—
Chulmleigh		1	2	D	—
Braunton		1	3	—	—
Kingskerswell ..		1	2	—	—
Exmouth		5	11	—	hospital grounds

D = Dispensary. O = Orthopaedic Clinic.

HEALTH CENTRES, Dr. Joseph Lyons
Published in *County Councils Gazette*, May 1970.

At the request of the County Councils Association I wrote an article on the subject of health centres, for publication in the *County Councils Gazette*. This is reproduced herewith.



Doctors discussing cases with nurses and health visitors

The provision of health centres with accommodation for family doctors, local health authority staff and other National Health Service staff and services has been a statutory responsibility of county councils and county borough councils since 1948. In the fifteen years up to 1963 only eighteen new centres were opened in England and Wales, but in the subsequent six years there was an upsurge of interest and 120 new centres were opened, of which not less than 87 were built by county councils. In 1969 alone 44 centres were opened and at the end of the year 95 were under construction, with a further 77 planned and approved.

The slow progress in earlier years had a number of causes, principally the lack of interest and often the distrust and suspicion of general practitioners. Many feared that moving into a health centre would mean a loss of professional independence, interference by the local authority or the MOH in their work, and an increased likelihood of salaried status. There was also a lack of incentive for such a move. Twenty years ago most doctors were content to work either in solitary isolation or in two-doctor partnerships and saw little advantage in working in larger groups or alongside local authority medical and nursing staff, especially when the increased cost of practising from well-equipped and adequately staffed modern premises could in no part be recovered from the Executive Council.

Doctor's Dilemma

Today, however, the circumstances of general practice are changed. The workload is heavier. There are more patients per doctor and many more elderly patients per doctor. The doctors need more time too for study, research and for

greater participation in hospital and local health authority work. But they also quite justifiably wish to taste the increased leisure now enjoyed by the rest of the community. This is a doctor's dilemma which can only be resolved by increased efficiency. This requires the delegation of some work to ancillary nursing and clerical staff. And staff, in turn, require accommodation, equipment and other facilities. The cost of these improvements can be shared with other doctors in group-practice premises, and some of the 'overheads' could in a health centre also be shared with the local health authority. Furthermore, working in a health centre facilitates (but does not ensure) more co-operation with the local authority's nursing and other community health services, so promoting a higher standard of medical care. Other advantages to the doctor in a health centre are the absence of a group-practice loan with its attendant financial and psychological irritations and the existence of an administrative machine in the local health department to assist with the staffing and management of the premises.

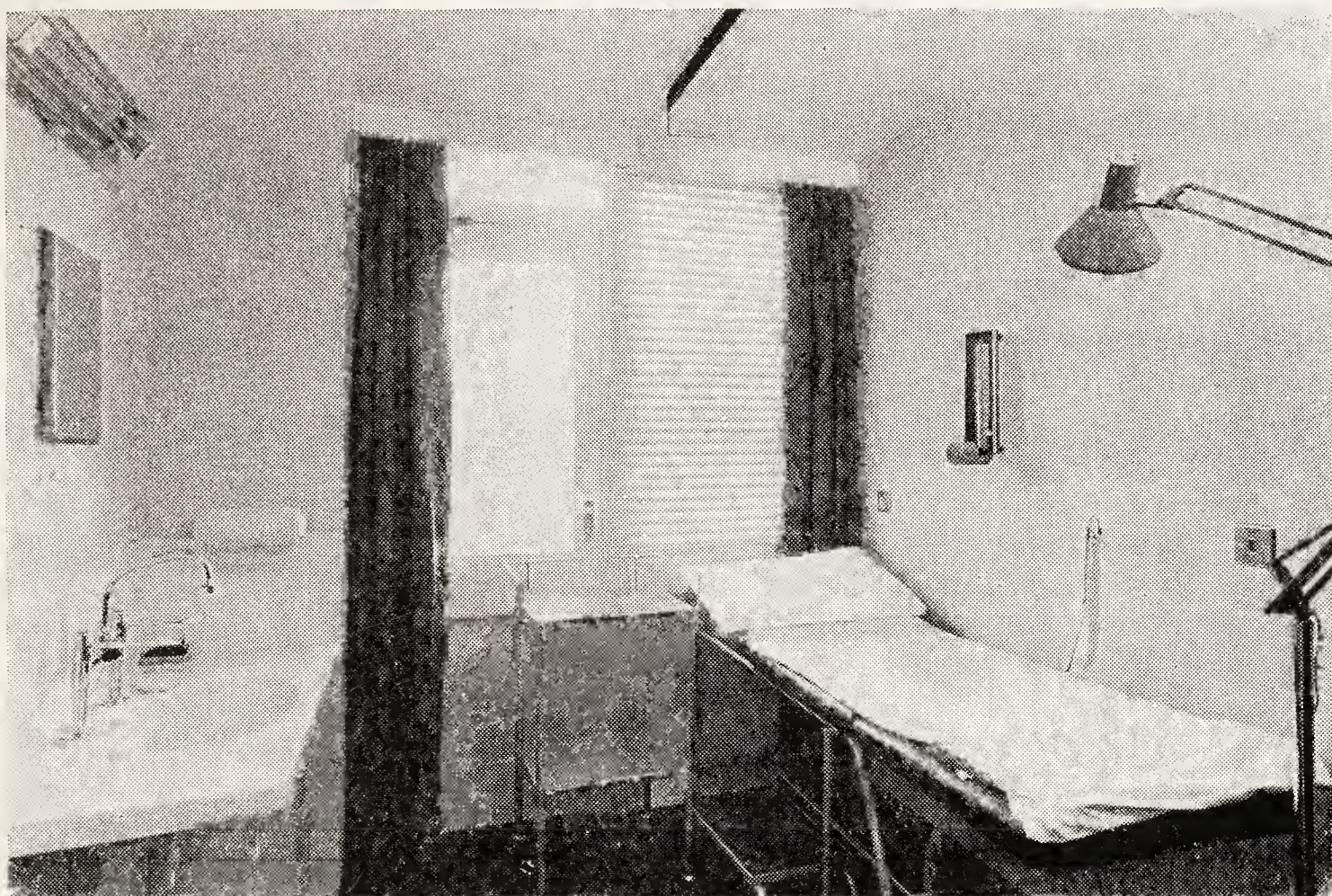
Reimbursement

The force of these arguments has impressed more and more family doctors in recent years, but until 1966 the financial sacrifice involved in moving to either group-practice or health centre premises was a formidable deterrent. The so-called 'Doctors' Charter' of 1966 transformed the situation. This was the agreement between the BMA and the Ministry of Health accepting the recommendations of the Review Body on Doctors' Remuneration. The most significant feature of this charter was the arrangement for the reimbursement in full by the Ministry of reasonable expenditure on the rent and rates of surgery premises, including those in health centres, and the partial reimbursement (up to 70 per cent) of the salaries of ancillary staff. The effect of this change on health centre finance is that a local health authority can now charge the Health Service Executive Council the full economic rent for part of the building without deterring the doctors, whose own payment in general consists only of 30 per cent of the ancillary staff salaries plus a contribution on an agreed basis for heating, lighting, cleaning, redecoration and repair, telephones, etc. These provisions have made health centres a much more attractive proposition to doctors and a more reasonable proposition to local authority finance committees.

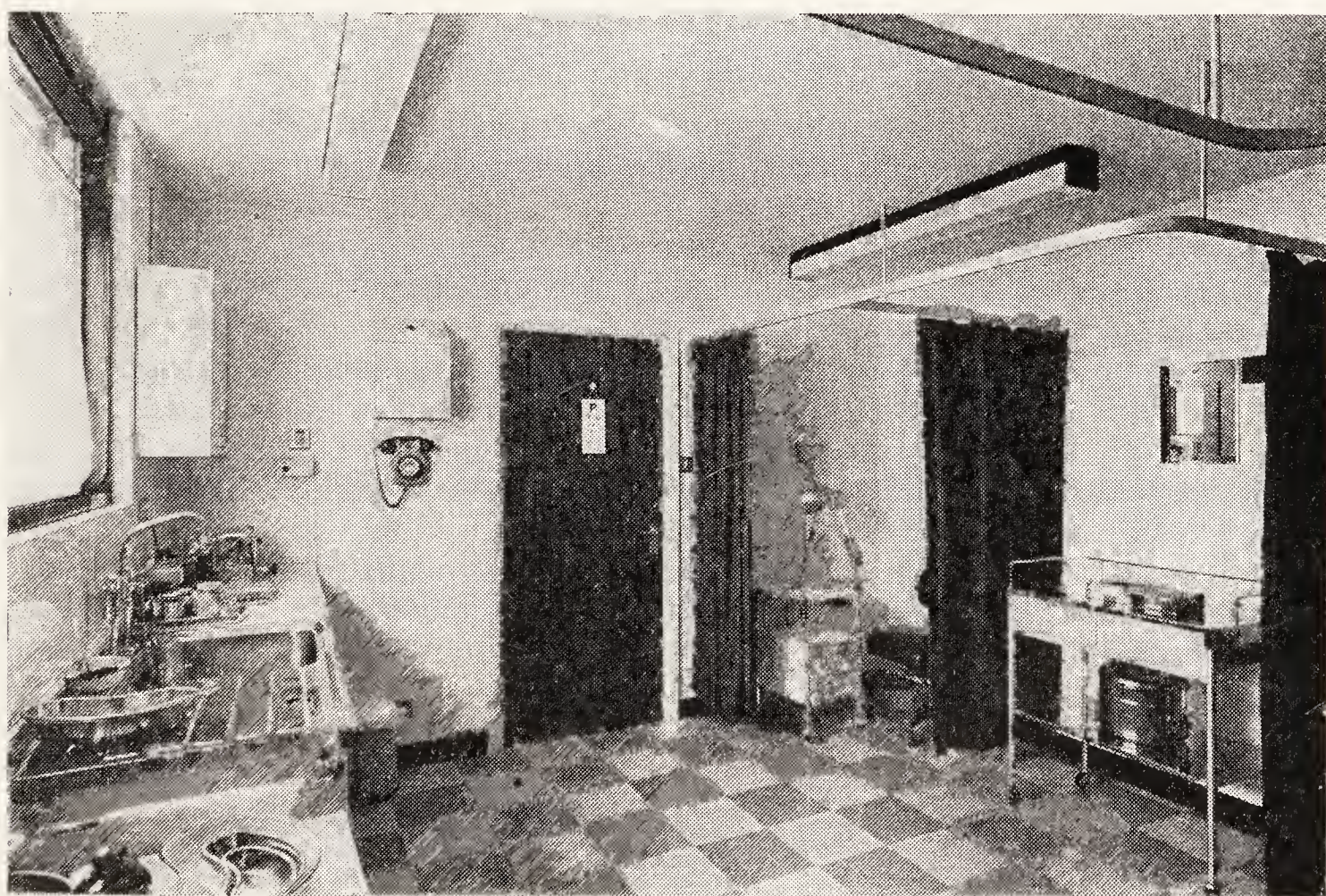
The attitude of local health authorities to health centres has, like that of the doctors, been shaped by the evolution of the National Health Service. The NHS Act of 1946 deprived county councils and county borough councils of their responsibilities in the field of hospital administration and replaced them with the task of developing services for the care of patients in their own homes. Thus we saw the expansion of existing services such as district nursing and health visiting and the introduction of other domiciliary services such as home helps, chiropody, social work, mental welfare, occupational therapy and so on. Almost all of the patients provided with these services were also under the active care of their family doctors and it soon became clear that, without the most active co-ordination and co-operation between health department and doctors, the domiciliary services could often be ineffectively or wastefully applied, and any advice given to patients by domiciliary staff which happened to conflict with the doctor's advice could cause confusion or even alarm in the minds of the patients and so discredit the service.

To obviate this risk many enlightened authorities introduced schemes of 'attachment' of health visitors, district nurses and midwives to general practices. This meant that instead of being allocated to a geographical area serving all the patients and their doctors in that area, the attached nurse would attend only the patients of a particular practice. The advantage of this arrangement is that the doctors of a practice deal mainly with one district nurse and her services are therefore used more effectively. A further logical development along these lines

is the provision of premises to enable family doctors and health department staff to work under the same roof. Some forward-looking doctors have at their own expense provided accommodation in their group-practice premises for health visitors and district nurses, but in the main we have to rely on health centres to meet these needs.



The examination room (above) and clinical/treatment room (below) at Salcombe Health Centre.



CCA Evidence

The renewed interest of county councils is clearly shown in the evidence recently submitted by the CCA to the Department of Health's medical advisory

sub-committee at present reviewing the organisation of group-practice. The CCA's memorandum came out very strongly in favour of health centres. Thus in paragraph 2 we read, 'In general health centres are the premises best suited for group-practice. In addition to accommodation facilities for preventive and curative medicine they provide general practitioners with the opportunity of working more closely with local authority health, education and social service staffs. As a base for local authority staff to work from the ideal is the purpose-built health centre . . .' The memorandum goes on to refer to some of the difficulties inherent in establishing centres. The cautious or suspicious attitude of some doctors is looked upon as the most serious factor, but this view would not be shared by county councils such as Devon and the West Riding, who are in the van of health centre development.

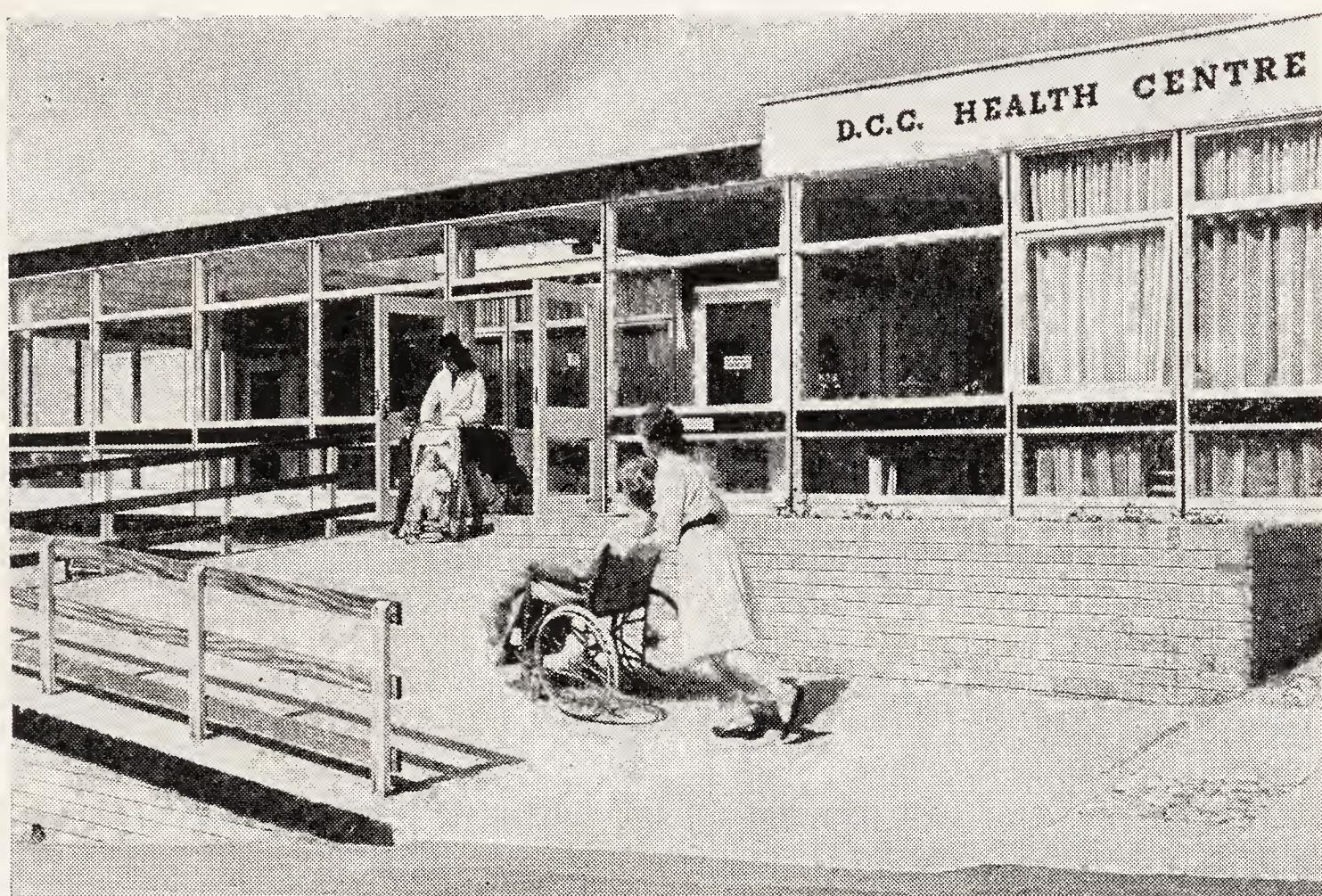
The Devon County Council began their programme only five years ago and, as soon as the first two or three were seen to be successful, many doctors not only dropped their opposition but pressed for more to be built. The result is that Devon now have twenty-three health centres in operation, serving a total population of over 100,000. One quarter of the doctors based in the country area now practise wholly or mainly from these premises and, if present plans come to fruition, the proportion of doctors will approach 50 per cent within the next five years. Of the remaining 50 per cent a considerable number are interested but, having recently spent considerable sums of money on new or renovated practice premises, are deterred by financial considerations. In three such instances, however, the County Council have purchased the doctors premises and enlarged and adapted them so as to constitute fully-operational statutory health centres, but this procedure is only occasionally practicable. On a few occasions interested doctors had to be discouraged because the Health Committee (and even the County Medical Officer!) could not establish a need for local authority accommodation in the area. The number of doctors in Devon who remain hostile to the health centre concept constitute a tiny and decreasingly vociferous minority. The overall picture is hardly that of a reluctant profession.

Rural Areas

Another possible source of difficulty mentioned in the CCA memorandum concerns the danger of creating intolerable travelling distances for patients in rural areas by the concentration of the surgeries of a number of scattered practices into a single centre. This has been almost completely avoided in Devon by the provision of a number of centres which would be regarded as unusually small by any preconceived standard. Of the twenty-three centres now in operation sixteen provide accommodation for one practice only, and no centre provides for more than two practices. The four smallest centres have only one family doctor apiece. The viability of the 'one-doctor' centre was initially questioned by the Department of Health but the need for a base for the health team in a scattered if small rural population is at least as pressing as in a larger and more compact community. The cost is minimised by the sharing of most of the accommodation between the doctor and local health staff, most of whom, e.g. chiropodist, home help organiser, occupational therapist, social worker, etc., visit only periodically. These centres enable the County Council to provide modern clinic facilities in areas where the building of separate clinics (for local authority use only) might have been prohibitively expensive. In the larger areas it had already been the intention of the authority to build new clinic accommodation, and the advent of the health centre programme made it possible to share some of the overheads with the Executive Council and the doctors and so reduce the cost. This explains why Devon have found it possible to make rapid progress even during a period of financial stringency.

One deterrent to local authorities not mentioned in the CCA memorandum is the extraordinary complexity of the preliminary planning and negotiations.

The acquisition of a site for a building project, always inherently difficult, becomes a much more formidable task when its suitability has to satisfy not only the local health authority and the Department of Health but also the Executive Council, every doctor intending to use it, and, if some hospital services are to be provided, the local hospital management committee and the regional hospital board. And in a county area the county council would be well advised to consult the district councils concerned and where appropriate the parish council.



The Ilfracombe Health Centre, showing ramped approach

Exercise in Diplomacy

The statutory procedure under section 20 of the NHS Act for advertising the intention of the authority to build a centre on a particular site is not a substitute for this gruelling but necessary exercise in 'grass-roots' democracy. When the site has finally been settled agreement has to be reached with all directly concerned, especially the doctors, on every item of accommodation, fixtures and equipment, down to such details as the exact positioning of power points, switches and telephones. No two health centres are identical; as far as is humanly possible each must be fashioned to meet local needs and individual requirements. The financial and staffing arrangements have also to be discussed with the Executive Council and the doctors, and legal contracts drawn up for agreement. The clerk's, architect's and treasurer's departments are all closely and strenuously involved and other departments within the county council such as education, welfare and children's may have an interest and must also be consulted. The operation as a whole is an exquisite exercise in diplomacy and an acid test of a local health department's efficiency.

Expenditure by county councils on health centres has more than quadrupled in the last two years. They must clearly now be regarded as an established feature of the pattern of medical care in this country. Proposed changes in the administration of the National Health Service would however remove from local authorities the responsibility for their provision. But it is to be hoped that no local authority will try to anticipate these uncertain changes by the cessation or slowing down of its health centre programme. The Seebohm Report made

repeated reference to the need for the closest possible co-operation between the new social service departments of local authorities and the National Health Service, while the recent NHS Green Paper has stressed the potential role of the health centre as a bridge between these two important and (alas!) separate institutions. Local authorities are bound to continue indefinitely to have a close and active interest in health centres.

AMBULANCE SERVICE

The work of the ambulance service over the last ten years has flattened out but this is probably only a temporary pause in the increasing demand accounted for largely by the creation of the Torbay County Borough.

Very encouraging progress has been made in the training programme. By the end of the year all but fourteen of the full-time staff had received training sufficient to qualify them for the top rates of pay. The training of these fourteen men will be completed by the end of the financial year. Three local induction courses have been held at County Hall during the year, which have been attended by men from the Torbay and Exeter county boroughs as well as from Devon. The instruction on these local courses is given by our own ambulance officers. Our officers are also seconded to Hampshire County Council to act as instructors on the courses which are run there for ambulance personnel from the whole of the South of England. The Hampshire training school has reported that both our men who attended these courses, and our officers who instruct on them, are well above average. The assistant county ambulance officer, who is responsible for training, has also been seconded to instruct on the course to train instructors, organised by the Cheshire County Council on behalf of the Department of Health and Social Security.

During the year two members of the staff have qualified as Associates of the Institute of Ambulance Officers, two as Fellows of the Institute of Certified Ambulance Personnel and one as an Associate of that Institute. In the National Ambulance Service Competition, Driver T. Cox of Barnstaple was adjudged the best ambulance attendant in the South-West Region.

TABLE SHOWING PATIENTS CARRIED BY THE DEVON
AMBULANCE SERVICE FOR THE YEAR ENDING:

	1968	1969
AMBULANCES		
Patients	66,701	65,747
Emergencies	7,599	7,042
Mileage	795,095	790,864
HOSPITAL CAR SERVICE		
Patients	329,607	326,978
Mileage	3,015,624	3,037,652
HIRED CARS		
Patients	13,534	15,716
Mileage	51,558	63,504
TOTALS		
Patients	409,842	408,441
Mileage	3,862,277	3,892,020

HOME NURSING AND HEALTH VISITING

Home Nursing Service

The number of patients nursed in their own homes notably increased during the year. The total of individual patients nursed was 12,681 (11,068 in 1968 including Torbay).

Because of changes in the administrative nursing staff no further progress was made during the year with schemes of attachment of nursing staff to general practices, although preparations were made for such schemes to commence at the beginning of 1970 in Branton, Ilfracombe, Combe Martin and Lynton. In the past, district nurses have always had a close liaison with their general practitioner colleagues but, with "attachment" instead of working for a specific geographical area, the district nurse works solely with the patients of a particular practice. The advantage of such an arrangement is that the nurse and doctor work as a team, with an improved service to the patient. There is a general increase of work, a quicker turnover of patients and a more interesting range of duties, which has made better use of nurses' skills.

Surgery Nursing. In the future more of the trained nurse's time will be spent working in the health centre or surgery, alongside the general practitioner. During the year there has been an increase of surgery nursing sessions, when the patient able to attend visits the surgery at an appointed time to receive treatment from the nurse. In some areas the nurse is in attendance each morning, before the doctor's surgery, and other sessions are held once or twice each week. Surgery work and district work are complementary—many patients previously treated at home are willing to come to the surgery to be seen at times by doctor and nurse together. If the patient defaults, the nurse pays a home visit. The doctor is relieved of some work, leaving him time for duties more relevant to his skills.

Lectures to Hospital Staff. During the year the nursing officers have given lectures to student nurses at the North Devon Infirmary, to student nurses taking district nurse training arranged by Exeter City Council, and participated in the first-line management course organised by the Technical College, Exeter.

District Nurse Training. Many full-time and part-time nursing staff in the county are not trained in community nursing. During the year the County Council received approval from the Department of Health for the county to become a district nurse training area. Staff will be sent to the Exeter and Plymouth training centres for day-release study once a week during the twelve-week course. Those who are successful will receive the National Certificate of District Nursing.

Registration of Nursing Homes. In 1968 one small maternity home closed when the owner left the district, and in 1969 one nursing home was re-registered on change of ownership. At the end of 1969 there were fourteen registered nursing homes, providing sixteen maternity beds and 195 medical and chronic beds.

Health Visiting Service

At the end of 1969 the establishment of health visitors was 71 and there were no vacancies. During 1968 and 1969 ten health visitor students completed their training and eight of these were given appointments in the county.

The health visitors are now organised in eight groups, each with a group adviser. In 1968 fourteen health visitors and three clinic nurses were transferred to the new County Borough of Torbay.

There are eighteen clinic nurses and one nursing assistant, five of whom work full time, five half time, and the remainder work only during school terms. They are employed within the groups and relieve the health visitors of routine work in schools and assist in certain clinics, such as cytology and retirement clinics.

The health visitor works with voluntary and statutory workers to try to ameliorate the conditions in which certain families, who present complex problems, live. All health visitors are car drivers and they are all on the telephone at home as well as in the clinics and health centres, so that they are readily available should there be an emergency in their areas.

Refresher courses are attended every five years. In-service training is given in the form of study days. In 1969 a successful residential weekend course was held and it is hoped to repeat this, as only part of the staff could attend.

Liaison with general practitioners has improved over the years and the majority of health visitors have their case-loads based on the families in group and single practices instead of geographical areas.

In areas where there is a county council clinic or health centre, health visitors may be contacted between 9 and 9.30 a.m. In most centres where there are clerks, messages may be left for the health visitor.

Further details of the health visitor's work may be found in the various sections of child and adult health, as her duties start before the birth of a child and run through the whole range of family life right up to the care of the elderly.

HEALTH EDUCATION

The health education unit has the following functions:

- (1) Advice in the technique and content of health education. This is given not only to health department staff but also to school teachers, social workers, general practitioners, voluntary agencies and others engaged from time to time in health educational work.
- (2) Provision of equipment, visual aids and materials, and the training in their use.
- (3) Assistance in in-service training courses for professional staff.
- (4) Assessment of health education needs.
- (5) Maintenance of the health education library which functions for the benefit of all professional staff within the department.

Among the topics dealt with are the following:

Veneral diseases

Family planning

Cancer prevention

Smoking and its associated diseases (obesity, lung cancer, bronchitis, cardiac disease)

Food hygiene (storage and handling)

Nutrition

Accident prevention (home, farm, water, school, industry)

Pre-retirement education

Control of infectious diseases

Living and Growing (physiology, growth and development, sex education, reproduction)

Child health (stages of physical and emotional growth)

Addiction (alcohol, smoking, drugs)

Dental health

PART VII

EPIDEMIOLOGY

Notification of Infectious Disease
Tuberculosis

NOTIFICATION OF INFECTIOUS DISEASE

Tables showing details of the above may be found in Appendix I and details of notifications, deaths and treatment of tuberculosis cases in Appendix J.

TUBERCULOSIS

Dr. Adkins, chest physician, reports as follows from the Chest Clinic at Ivybank, Exeter.

“The figures for notification (which may be found in Appendices E and F) show no significant change from last year. They do show that the relative proportion of non-respiratory tuberculosis remains high, and this is occurring mainly in the elderly, who have provided the majority of respiratory cases for many years. The older age groups provide treatment problems as they tolerate the toxic antituberculous drugs less well. However, some of the newer drugs, particularly ethambutol and rifampicin, appear to be well tolerated and may be of value when our experience of them has grown, and we hope their cost has dropped.

The chest clinic has been operating an open session on the static camera unit for some time now and the numbers referred are steadily increasing to the point when the present staff are hard pushed to cope. This over-loading is partly due to the contraction of the mass X-ray service in the area and the unit is being used for purposes not visualised when the service started. It is to be hoped that further re-appraisal will not result in further cuts in the mass X-ray service, which has provided such a valuable mobile chest X-ray for many years, particularly to areas remote from other X-ray units.

Last year I referred to aspergillosis as a non-tuberculous chest condition which could provide a public health problem. Another such condition, of particular importance to this county, is farmer’s lung and we are becoming increasingly aware of the disablement this condition causes, probably increasing with modern farming methods. The management of this condition is less medical than industrial and education of the farming community is the basis of this. Busy farmers have little time for education and perhaps this should be diverted to the younger generation in our rural schools.”

Dr. Dawson, chest physician, reports as follows from the Plymouth area.

Notifications

The number of notified cases of tuberculosis during the year amounted to 10 respiratory forms of tuberculosis; and 1 non-respiratory.

Table 1

<i>Respiratory</i>		<i>Non-Respiratory</i>	
<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
7	3	—	1

Table 2

Source of Notified cases of Respiratory Tuberculosis

<i>Year</i>	<i>M.M.R.</i>	<i>Gen. Pract.</i>	<i>G.P. X-ray</i>	<i>School Medical Service</i>	<i>Contacts</i>	<i>Other Hospitals</i>	<i>TOTAL</i>
1969	2	4	—	—	—	4	10

Table 3
Notifications and Deaths from Tuberculosis

<i>Notifications</i>		<i>Deaths</i>		<i>Deaths in non-notified Persons</i>	
<i>Resp.</i>	<i>Non-Resp.</i>	<i>Resp</i>	<i>Non-Resp</i>	<i>Resp</i>	<i>Non-Resp.</i>
10	1	—	—	1	—

Deaths

During the year there were 12 deaths of patients on the Chest Clinic Register. Respiratory Tuberculosis was registered posthumously as the cause of death in 1 case.

Clinic Register

An analysis of the number of patients on the “live” Chest Clinic Register at the end of the year is shown in Table 4.

	Table 4			
	<i>Male</i>	<i>Female</i>	<i>Children</i>	<i>TOTAL</i>
Respiratory Tuberculosis	14	2	5	21
Non-respiratory tuberculosis	4	8	1	13

Chest Clinic and Hospital Work

<i>Attendances</i>	<i>New cases referred</i>	<i>New Contacts</i>	<i>Re-attendances</i>	<i>TOTALS</i>
Beaumont House	132	35	290	457
Launceston	7	—	29	36
Tavistock	35	—	189	224
	174	35	508	717

As from 1st January, 1969, the chest clinic at Stratton Hospital was administered by the North Devon H.M.C.

Table 5
General Practitioners Open X-ray Session

Referred by G.P's.	—	323
Contacts/Old Cases	—	35

X-ray Session (Large Film)

This weekly X-ray session is attended by patients who have “recovered” from pulmonary tuberculosis and who are X-rayed annually. The number of patients who attended during 1969 was 53.

Table 6
Bacteriology of New Cases of Respiratory Tuberculosis

<i>Total No. Notified</i>	<i>No. sputum positive</i>	<i>No. infected with resistant strain</i>
10	4	1

Chronic Sputum Positive Cases

There are no chronic sputum positive cases in the West Devon Area.

B.C.G. Vaccination

During the year 36 cases were vaccinated against tuberculosis.

PART VIII

MISCELLANEOUS

**Capital Building Programme
Fluoridation of Water Supplies**

CAPITAL BUILDING PROGRAMME

Section 21—Health Centres

Completed during 1968:

Ashburton	Combe Martin	Kingsteignton
Budleigh Salterton	Cullompton	Northam
Bovey Tracey	Gt. Torrington	South Molton
Colyton		

Completed during 1969:

Holsworthy	Salcombe	South Brent
Ivybridge	Sidmouth	Yealmpton

Completed in earlier years:

Buckfastleigh	Lynton	Ottery St. Mary
Ipplepen	Okehampton	Seaton
Ilfracombe		

Ambulance Station

The Holsworthy Station was constructed as part of the Health Centre project and provides accommodation for one ambulance.

Adult Training Centres

The 50 place Tavistock Centre was completed towards the end of 1968 and was named after Alderman Molly Owen, the Vice-Chairman of the Health Committee and Chairman of the Adult Health Sub Committee.

A 50 place centre was built at Axminster and brought into use in 1969. It was named after the late Mrs. Phillips who was Chairman of the Health Committee for nearly 20 years.

At Kingsteignton, the building of a 120 place Training Centre is expected to start during 1970.

Adult Hostels

Building is under way on a 27 place Hostel at Axminster which will be ready for occupation during 1970.

Sheltered Workshops

The County's first Sheltered Workshop was completed at Barnstaple and has been named after Councillor Ivor Thomas, the Vice-Chairman of the Adult Health Sub Committee.

Chiropody Laboratory

It is believed that the appliance making laboratory which was completed in 1968 is the first of its kind to be opened by a local health authority.

FLUORIDATION OF WATER SUPPLIES

Like most parts of Britain, Devon does not have enough naturally occurring fluoride in its water supplies to produce teeth which are more resistant to dental decay. Against the recommended level of one part per million which is guaranteed to reduce decay by up to half, the county water supplies contain only 0.01 parts per million of fluoride. Since 1963, successive Ministers of Health, from Mr. Enoch Powell to Mr. Richard Crossman, have strongly advised local authorities to implement fluoridation of water supplies. The County Health

Committee responded to Mr. Crossman's 1969 Circular by pronouncing in favour of fluoridation for Devon, but the County Council in February, 1970, adhered to its earlier decision of January 1966, and voted 42-19 against the principle of fluoridation. Thus, twice in four years, this county has denied its children and future adults the proven benefits of fluoridation.

Emotions run high when fluoridation is discussed and reasoned judgment of authoritative evidence is often clouded by the claims of individuals or bodies with no expert status. No single authoritative body of doctors, dentists or scientists in this country has ever opposed fluoridation, which remains unrivalled as the safest preventive health measure ever proposed in Britain. The ethical question of whether fluoridation restricts personal freedom must, as with every other preventive health question, be considered alongside the other ethical question, namely, whether it is proper for a local authority to ignore expert advice and deprive the public of the most effective measure known to man for reducing dental decay. Senior members of the Staff in the Health Department have given talks on dental hygiene and fluoridation to many parents' organisations and it has been clear that the vast majority of parents in Devon do not oppose fluoridation. I sincerely hope that we must not wait another 4 years before this most important issue is again debated in Devon.

PART IX

FOOD AND MILK

Water Supplies

Sewerage and Sewage Disposal

FOOD AND MILK

The County Council employs five Sampling Officers, who are always available to investigate consumer complaints. Their names and addresses are shown in Appendix P, but if it is more convenient, a 'phone call to the Local District Council Offices or to this Department will ensure the speedy attention which is so essential.

The Sampling Officers, in addition to dealing with consumer complaints, obtain routine samples of every type of commodity which is used for human consumption, as food or drink, and the Public Analyst normally finds that at least 95% of all the samples submitted to him are completely satisfactory. Even in the remaining 5% of cases, informal action will normally put matters right, but the County Council would not hesitate to initiate a prosecution if the circumstances warranted it. A following paragraph gives a list of the foreign bodies which have been found in food recently, and the list makes very interesting reading.

The five Sampling Officers in the county are supervised by the County Health Inspector. Food and Drugs Act samples other than milk are sent to the Public Analyst for examination, but the majority of milks are subjected to the gerber test in this Department and only the suspicious samples are submitted to the Public Analyst. In addition, a proportion of samples are sent each week for testing for the presence of antibiotics and Pesticidal Residues.

During the period 1,485 formal and 591 informal samples were submitted to the Public Analyst, whilst 2,513 samples of milk were subjected to the gerber test in the Department's own laboratory.

The Public Analyst reported that of the 2,076 samples he received, 162 were either adulterated or gave rise to some other irregularity. Seventy-three of the samples were of milk and 40 of these were ones in which the non-fatty solids and/or butter fats were below the normally accepted figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food and Drugs Act was being committed. Of the remainder, 30 were found to contain added water and 3 contained a small amount of penicillin. Six vendors were prosecuted.

The remaining 89 samples other than milk reported on by the Public Analyst, included a sliced loaf containing a powder-post beetle embedded in the crumb of the bread, jam deficient in fruit, a stone embedded in the pastry of a jam puff, incorrect labelling and misleading descriptions, mould in various pastries, rancid sugar confectionery, glycerin deficient of the required minimum proportion of anhydrous glycerin, pasties deficient of the required proportion of meat, a bun containing string, a tin of corned beef containing a mass of ox hair, nylon thread in a pasty, soft drink bottle containing glass, bottles of milk containing foreign matter, fruit salad deficient of the required proportion of peaches, pork sausage meat deficient in meat, foreign body in a packet of cereal, custard tart containing a house fly, fruit pie containing a strip of tinned steel, splinters of hard wood in caramels, incorrect labelling, a packet of cake fingers containing a cigarette end, two pieces of wire in a loaf of bread, and a tin of carrots containing a piece of chalk. Ten of these cases resulted in prosecution and similar action was recommended in others; warning letters were sent in many instances.

The Sampling Officers take their samples with very considerable care and selectivity. Apart from the help given in this Department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other counties and published accounts of the legal action taken by other Food and Drugs authorities.

All complaints of alleged infringements of the principal Acts or the many Regulations, etc., made under it are very carefully examined and the co-operation of the public and of other local authorities is welcomed. I hope that this assistance will increase in the future.

Brucella Abortus

A sampling programme to identify herds secreting the Brucella organism in their milk was commenced in 1963, and in the first four years then the number of individual samples found to be Positive averaged between 30 and 40.

Most authorities are satisfied that the consumption of infected raw milk is a public health risk, which should be prevented wherever possible, and in 1966 the Ministry of Health issued a circular advocating the regular sampling of milk from all herds whose milk was sold untreated.

As a result, our sampling programme was stepped up even more, and in 1968 43 Positive cultures were isolated and 57 in 1969.

Immediately a positive culture is known, the Medical Officer of Health for the district and the Divisional Veterinary Officer are informed and steps are taken to prohibit the sale of the infected milk and to trace the offending animal or animals. Normally, two consecutive negative results are required before the raw milk is allowed to be consumed again and the number of samples taken is increased.

Total number of samples of Untreated Milk submitted	2,948
Number Positive on Ring Test, but Negative on Culture	279
Number Positive on Culture	100

The Milk (Special Designation) Regulations 1963

During the year the following samples were submitted:

	<i>Total</i>	<i>Number failed Phosphatase test</i>
Pasteurised	2,715	Nil
	<i>Total</i>	<i>Number failed Methylene Blue test</i>
Pasteurised	2,715	140
Untreated	1,902	431
	<i>Total</i>	<i>Number failed Turbidity test</i>
Sterilised	35	Nil
	<i>Total</i>	<i>Number failed Colony Count</i>
Ultra Heat Treated	6	Nil

When a sample fails to pass the prescribed test, an immediate inspection of the dealer’s premises is made and repeat samples are taken where necessary. If it is thought that the failure, in the case of untreated milk, is the fault of the producer, the Ministry of Agriculture, Fisheries and Food’s Divisional Milk Officer is informed.

MILK

The County Dairy Husbandry Adviser of the Ministry of Agriculture, Fisheries and Food informs me that at the end of 1969, there were 6,780 registered milk producers, a decline of 225 on the previous year. 536 licenses permitting the sale of “Untreated” milk by producer/retailers were in operation, a decrease of 28 during the year.

ANIMAL HEALTH DIVISION—DEVON

The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food, Mr. G. S. Reid Chalmers, reports as follows:

Livestock (Census 4th June, 1969)

Cattle	583,731	Pigs	239,061
Sheep	1,322,067	Poultry	4,222,034

Eradication of Tuberculosis

<i>No. of herds tested</i>	<i>No. of cattle tested</i>	<i>No. of herds in which reactors were disclosed</i>	<i>No. of reactor herds in which lesions were found at p.m.</i>	<i>Reactors Showing lesions at p.m.</i>	<i>Disclosed Showing no lesions at p.m.</i>
5,001	259,069	16	16	9	14

Scheduled Diseases

There were no reported cases or suspected cases of Foot and Mouth Disease, Swine Fever or Fowl Pest during 1969. 158 cases of Anthrax were reported, of which 6 were confirmed.

Free Calf Vaccination Service

No. of herds registered at 31st December, 1969, for Free Calf Vaccination Service	..	..	..	..	..	8,039
No. of calves vaccinated in 1969	..	..	..	..	..	63,777

Brucellosis Accredited Herds Scheme

No. of herds participating in the scheme at 31st December, 1969	1,088
No. of accredited herds at 31st December, 1969	.. .. . 502

WATER SUPPLIES

Owing to financial stringency, the number of water main extensions has slowed down, but it is fair to say that the Water Boards had almost reached the end of their most urgent main laying programmes; 1970 should see the momentum increasing again but, looking to the years to come, it is obvious that the chief problem will be the provision of very large permanent sources of supply to meet the anticipated demands of the years up to A.D. 2000.

Water Boards in the county have all been active during the year, and all have substantial schemes either in course of construction or awaiting the consent of the Ministry of Housing and Local Government. This progress is emphasised by the amount of precept which each Board makes on the County Council.

Comparative figures are as follows:

	<i>1967-68 Actual Cost £</i>	<i>1968-69 Actual Cost £</i>	<i>1969-70 Probable Cost £</i>
North Devon Water Board	205,080	205,600	223,000
South West Devon Water Board	45,998	44,711	47,500
East Devon Water Board	33,543	31,185	37,400

The North Devon Water Board now covers an area of 1,664 square miles, approximately 1,344 miles of mains have been laid, and the average quantity of water supplied is over 10.3 million gallons per day. The total capital expenditure to 31st March, 1969 was £7,768,897.

The South West Devon Water Board was formed under Ministerial Order to operate from 1st October, 1963, and its statutory area includes the County Borough of Torbay, the Boroughs of Dartmouth and Totnes, the Urban Districts of Ashburton, Buckfastleigh, Dawlish, Kingsbridge, Newton Abbot, Salcombe and Teignmouth, the Rural Districts of Kingsbridge, Newton Abbot and Totnes and that part of the Rural District of St. Thomas lying to the south of the River Exe. The area is approximately 500 square miles and the total amount of water put into supply in 1969 was 4,715 million gallons. The total Capital Expenditure to the 31st March, 1969 was £7,622, 265, including the book value of assets transferred under the Order. The outstanding debt at the 31st March, 1969 was £4,618, 196. Up to the 31st December, 1969 the new Board had laid 194 miles of mains.

The East Devon Water Board was reconstituted on the 1st October, 1964 and now comprises the authorities of the original Board, together with the County Borough of Exeter, the urban districts of Budleigh Salterton, Exmouth, Seaton and Sidmouth, the whole of the St. Thomas Rural District area east of the River Exe and the District Water Undertaking of the Colyton Feoffees. The total area covered by the Board amounts to 343 square miles. During the year, capital works amounting to £154,112 were initiated. The total capital expenditure of the authorities included in the Board amounted to £4,851,525 at the 31st March, 1969. Of this figure, £2,209,606 was incurred by the Board itself and £2,641,919 represented the debt of transferred undertakings.

At the 31st March, 1969, 486,636 yards of main had been laid by the Board and another 10,195 yards had been authorised to be laid. During 1968-69, 29,390 yards were laid. Since the Board came into operation on the 1st April, 1951, approximately 276 miles of pipes have been laid.

During the year grants under the Rural Water Supplies Acts were agreed to in principle on the following schemes:

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost</i> £
West Somerset Water Board	Brinscott, Holcombe Rogus	2,000
South West Devon Water Board	Ugborough	1,150
	Haytor, etc.	45,000
	Higher Rocombe	2,200
	Lindridge Hill, Kingsteignton	1,890
	Belsford, Harberton	1,225
	Hannaford, Poundsgate	1,575
	Yalton, East Portlemouth	2,350
	Soar, Malborough	2,800
	Lower Town, Leusdon	3,400
	Bradley Estate, Bovey Tracey	2,925
	Sigford Cross, etc., Ilsington	4,400
	Ashcombe and Dawlish West	23,000
	Hingston Borough area of Aveton Gifford	3,100
	Hayne Cross and Town Barton, Manaton	1,500
	Stormsdown, Ashburton	6,750

SEWERAGE AND SEWAGE DISPOSAL

Here again, financial stringency has somewhat curtailed the number of schemes which were carried out in 1968 and 1969, but there is every reason to suppose that there will be a new impetus in 1970. Much more remains to be done

than in the case of water supply, and during the next decade it is quite clear that a number of villages which were given Sewerage and Sewage Disposal Schemes in the 1930s will now have to be provided with modern and extended systems. I cannot, therefore, foresee any slowing down in this sphere.

The following schemes submitted to the County Council for financial assistance were examined by the County Health Inspector and were also submitted to the County Planning Officer for his examination, with the result that a joint report was made to the General Purposes Sub-Committee of the Health Committee from both Departments.

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost</i> £
Ashburton U.D.C.	Re-sewering of Town	34,287
Barnstaple R.D.C.	Croyde (Phase 1)	33,500
Bideford R.D.C.	Woolsery	34,995
Crediton R.D.C.	Bow	122,500
Crediton R.D.C.	Copplestone/Yeoford	279,500
Dartmouth B.C.	Sewerage Disposal Works	400,000
Dartmouth B.C.	Victoria Road Sewerage	30,000
Exmouth U.D.C.	Straight Point	684,000
Holsworthy R.D.C.	Dobles Lane	4,853
Holsworthy R.D.C.	Bridgerule	31,651
Holsworthy R.D.C.	Clawton	27,332
Holsworthy R.D.C.	St. Giles-on-the-Heath	29,318
Holsworthy R.D.C.	Pyworthy	27,830
Honiton B.C.	Extension of Sewerage Works	25,800
Honiton R.D.C.	Dulford	8,000
Honiton R.D.C.	Feniton	68,060
Honiton R.D.C.	Kerswell	16,000
Honiton R.D.C.	Upottery	13,550
Kingsbridge U.D.C.	Sewerage Disposal Works	227,610
Kingsbridge R.D.C.	Bigbury-on-Sea/Challaborough	175,000
Lynton U.D.C.	Barbrook	39,376
Newton Abbot R.D.C.	Bishopsteignton, Chudleigh, Haytor, Heathfield, Ipplepen, Kingskerswell, Moretonhampstead	12,130
Newton Abbot R.D.C.	Bovey Tracey	11,100
Newton Abbot R.D.C.	Denbury	93,800
Newton Abbot R.D.C.	Ogwell	32,550
Newton Abbot R.D.C.	Sandygate	16,000
Newton Abbot R.D.C.	Teigngrace	16,000
Newton Abbot R.D.C.	Battle Road Pumping Station	20,000
Newton Abbot R.D.C.	Heathfield Regional Scheme	18,500
Newton Abbot R.D.C.	Heathfield Regional Scheme	867,000
Newton Abbot U.D.C.	Keyberry Road Sewerage	35,500

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost</i> £
Newton Abbot U.D.C.	Forde Road Pumping Station	660,300
Okehampton R.D.C.	Belstone, Sticklepath, South Zeal, South Tawton	143,240
Okehampton R.D.C.	Throwleigh	39,208
Plympton R.D.C.	Heybrook Bay	34,000
Plympton R.D.C.	Ivybridge	387,000
Plympton R.D.C.	Newton Ferrers and Noss Mayo	506,300
St. Thomas R.D.C.	Dunsford	93,000
South Molton R.D.C.	Burrington	16,300
Tavistock R.D.C.	Harrowbeer	18,916
Tavistock R.D.C.	Lewdown	58,320
Tavistock R.D.C.	Horrabridge	3,460
Tiverton R.D.C.	Thorverton	66,200
Tiverton R.D.C.	Willand	66,300
Tiverton R.D.C.	Cullompton	8,100
Totnes R.D.C.	Marldon and Compton	90,000
Totnes R.D.C.	Ugborough	12,522

STATISTICAL APPENDIX

Births and Deaths	A
Statistics—County of Devon 1968 and 1969	B
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Mortality Rates	D
Causes of death	E
Causes of death at different periods of life 1968 and 1969						F
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Sampling Officers	P

Births

Registered live births in 1969 were 5,954, compared with 6,039 in 1968.

The corrected live birth rates for the past ten years for the boroughs and urban districts, rural districts and the administrative county, together with the national rate, are set out below:

	<i>Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>	<i>England and Wales</i>
1960	14.2	16.9	15.5	17.1
1961	14.5	17.0	15.1	17.4
1962	14.8	17.8	16.1	18.0
1963	17.4	18.3	17.9	18.2
1964	18.3	18.4	18.3	18.4
1965	17.7	18.4	18.2	18.0
1966	17.6	17.7	17.6	17.7
1967	17.6	16.8	17.2	17.2
1968	17.3	16.8	17.0	16.9
1969	17.3	16.2	16.6	16.3

Deaths

The total number of deaths allocated to the administrative county was 6,594 in 1968 and 6,631 in 1969 compared with 7,751 in 1967.

Due to the age/sex distribution of the population differing from area to area throughout the county, crude rates although based on actual occurrences fail to provide a useful mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past six years, adjusted by the appropriate factors, for the aggregates of boroughs and urban districts, rural districts and the administrative county, also the rates for England and Wales, are given below.

Adjusted Death Rates

<i>Year</i>	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>	<i>England and Wales</i>
1964	10.9	10.1	10.4	11.3
1965	10.3	10.2	10.2	11.5
1966	10.7	10.4	10.6	11.7
1967	9.7	9.9	9.8	11.2
1968	9.9	10.9	10.4	11.9
1969	10.0	10.5	10.4	11.9

STATISTICS—COUNTY OF DEVON 1968

Districts	Populations (Estim'td) Home	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Malignant & Other Unspecified Neoplasms	Vascular and Other Lesions of Nervous System	Heart and Circulatory System	Respiratory (ex- cluding Tuber- culosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
			No.	Rates per 1,000 Population		Under 4 weeks	Under 1 year											No.	Crude Rate	Cor'd Rate
				No.	No.															
Budleigh Salterton Exmouth St. Thomas	3,970	1,330	31	7.8	12.6	—	—	—	14	19	38	10	2	—	—	3	4	90	22.7	10.9
	23,200	6,930	286	12.3	17.8	1	2	2	75	78	158	29	20	13	—	18	13	406	17.5	8.8
	30,310	4,550	439	14.5	15.8	5	1	3	76	79	171	113	19	5	—	14	30	510	16.8	10.4
Ottery St. Mary Sidmouth Honiton	5,500	820	74	13.5	19.4	1	—	—	16	7	26	9	2	2	—	2	—	64	11.6	7.4
	11,990	4,150	87	7.3	13.9	2	—	1	54	34	98	28	9	4	—	13	11	252	21.0	9.0
	5,800	630	133	22.9	23.1	1	1	1	7	19	32	9	2	—	—	3	2	75	12.9	7.6
Seaton Axminster Honiton	3,840	1,180	32	8.3	13.6	—	—	—	11	9	26	8	2	2	—	—	4	62	16.1	7.2
	14,800	3,130	176	11.9	15.6	—	3	1	52	33	81	21	5	3	—	4	10	210	14.2	10.8
	7,410	1,320	125	16.9	19.8	1	1	—	14	7	32	13	5	1	—	2	7	81	10.9	10.2
Crediton Crediton Tiverton	4,980	830	92	18.5	19.2	—	—	—	11	10	22	11	1	—	—	4	2	61	12.2	10.7
	9,870	1,510	146	14.8	16.6	2	1	1	24	23	26	10	3	3	—	8	5	103	10.4	9.8
	14,540	2,490	251	17.3	18.3	1	—	3	51	25	70	25	3	1	—	4	10	192	13.2	10.3
Tiverton	20,870	3,820	306	14.7	16.6	3	—	3	58	43	110	42	7	8	—	11	10	292	14.0	11.5
	Barnstaple Barnstaple South Molton	16,820	2,360	269	16.0	16.8	5	—	—	39	123	28	3	5	—	11	6	259	15.4	12.3
		28,460	4,990	429	15.1	18.0	2	3	3	44	58	155	28	7	3	—	15	17	370	13.0	10.9
11,310		1,700	161	14.2	16.9	1	—	—	84	25	64	16	8	6	—	7	5	158	14.0	10.9
Ilfracombe Torrington Northam	8,210	2,020	115	14.0	17.9	—	—	—	27	29	61	13	7	5	—	4	1	154	18.8	12.6
	7,320	1,240	79	10.8	12.9	—	—	—	34	9	42	6	1	—	—	4	5	85	11.6	10.7
	7,580	1,700	89	11.7	17.1	—	—	—	18	18	51	18	4	5	—	8	4	137	18.1	10.3
Bideford Holsworthy Great Torrington	11,030	1,500	177	16.0	18.1	—	—	—	29	27	76	16	11	6	—	9	8	181	16.4	12.5
	8,330	1,530	121	14.5	16.8	2	—	1	28	18	43	4	2	1	—	9	6	107	12.8	10.5
	3,010	480	49	16.3	19.4	1	—	—	23	5	33	5	3	1	—	4	1	61	20.3	9.1
Great Torrington Bideford Lynton	5,140	730	87	16.9	19.6	1	—	1	9	7	32	8	1	3	—	2	3	69	13.4	12.6
	1,700	410	22	12.9	14.7	—	—	—	12	6	10	—	1	—	—	3	—	24	14.1	8.5
	Salcombe Kingsbridge Kingsbridge	2,430	450	24	9.9	13.2	—	—	—	9	3	10	1	2	3	—	1	3	32	13.2	8.1
3,340		440	36	10.8	12.6	—	—	1	7	9	15	8	—	—	—	1	1	41	12.3	10.7
12,020		2,520	128	10.6	12.9	1	3	2	41	25	67	20	2	6	—	6	2	171	14.2	11.8
Plympton St. Mary Tavistock *Totnes	14,620	1,840	200	13.7	14.0	3	—	—	33	32	73	29	—	2	—	6	4	179	12.2	10.5
	23,190	3,820	344	14.8	17.8	3	4	1	62	53	147	32	8	4	—	18	11	336	14.5	11.8
	14,290	2,900	189	13.2	16.5	1	—	1	33	41	82	31	7	6	—	12	6	219	15.3	8.9
Totnes Buckfastleigh Dartmouth	5,630	1,170	73	13.0	15.5	2	—	1	8	21	42	16	2	—	1	30	3	124	22.0	12.7
	2,510	460	35	13.9	18.5	—	—	1	6	6	24	3	2	—	—	1	1	44	17.5	12.8
	7,160	1,100	65	9.1	10.3	—	—	1	19	13	28	8	2	1	—	4	3	79	11.0	10.3
Ashburton Dawlish Teignmouth	3,410	580	51	15.0	18.5	—	—	—	11	6	18	8	—	1	—	1	1	46	13.5	9.2
	7,790	2,430	110	14.1	19.0	1	1	1	26	16	52	18	6	2	—	5	6	132	16.9	11.8
	12,220	2,460	150	12.3	19.1	2	—	2	47	32	90	19	4	3	—	11	6	214	17.5	8.8
Newton Abbot *Newton Abbot	18,700	3,590	269	14.4	16.0	3	2	1	43	76	112	40	14	4	—	24	9	323	17.3	10.0
	28,830	6,120	392	13.6	16.0	3	3	4	100	72	158	50	9	4	—	21	17	435	15.1	11.3
	Okehampton Okehampton	3,830	770	48	12.5	14.1	1	—	—	12	16	24	10	2	2	2	—	2	71	18.5	12.0
11,300		1,980	149	13.2	16.9	1	—	—	28	26	60	16	3	3	1	6	2	145	12.8	10.5
Administrative County		437,260	83,980	6039	13.8	17.0	50	27	36	1260	1074	2582	779	191	118	2	311	241	6594	15.1	10.4

*As there has been a change of boundary during the year, the statistics shown in the areas starred represent the events assigned to the area within the boundaries as they existed at the date of registration of each event. To allow calculation of valid birth and death rates, the figure shown under "Estimated Mid-Year Population" is a weighted average of the mid-year population of the area as constituted before and after the change. This population figure is calculated only for the purpose described above and will not agree with the official population figure published in the area as constituted before and after the change.

Districts	Popula- tions (Estim'td) Home)	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Malignant & Other Unspecified Neoplasms	Vascular and Other Lesions of Nervous System	Heart and Circulatory System	Respiratory (ex- cluding Tuber- culosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
			No.	Rates per 1,000 Population		Under 4 weeks	Under 1 year											No.	Crude Rate	Cor'd Rate
				Crude Rate	Cor'd Rate	No.	No.													
Budleigh Salterton Exmouth St. Thomas	3,960	1,330	33	8.3	13.4	—	—	—	27	17	42	12	5	4	—	—	2	109	27.5	12.1
	23,630	7,060	303	12.8	18.6	3	3	2	85	77	163	50	13	11	—	16	23	440	18.6	8.7
	30,850	4,640	384	12.4	13.5	5	4	3	77	67	182	85	13	10	—	25	34	496	16.1	9.5
Ottery St. Mary Sidmouth Honiton	5,770	860	97	16.8	24.2	—	—	1	19	14	25	5	3	—	—	4	3	74	12.8	8.2
	12,180	4,220	120	9.9	18.8	—	1	3	47	36	106	26	8	3	—	12	11	252	20.7	9.1
	6,160	670	113	18.3	18.5	—	3	—	8	16	27	10	2	1	—	3	5	72	11.7	7.1
Seaton Axminster Honiton	3,940	1,220	43	10.9	17.9	—	—	—	20	7	38	11	—	3	—	1	3	83	21.1	9.1
	14,770	3,130	153	10.4	13.6	2	—	2	42	28	80	24	4	3	—	7	6	196	13.3	10.1
	7,580	1,350	123	16.2	19.0	—	2	—	16	18	21	13	1	—	—	5	5	79	10.4	9.6
Crediton Crediton Tiverton	5,090	850	87	17.1	17.8	1	1	—	21	15	29	16	1	2	—	5	1	90	17.7	16.1
	9,870	1,510	131	13.3	14.9	3	1	1	22	20	46	16	2	3	—	9	2	121	12.3	11.6
	14,810	2,540	273	18.4	19.5	1	1	—	34	37	53	31	4	2	—	7	6	174	11.7	9.4
Tiverton	20,820	3,820	305	14.6	16.5	2	3	—	51	46	122	27	9	4	—	17	15	291	14.0	11.8
Barnstaple Barnstaple South Molton	16,850	2,370	285	16.9	17.7	4	1	1	49	36	79	23	6	3	—	9	13	219	13.0	10.1
	28,650	5,030	421	14.7	17.5	4	—	1	92	44	125	32	6	9	—	10	10	329	11.5	9.7
	11,210	1,690	127	11.3	13.4	1	1	1	29	23	76	19	7	4	—	9	5	173	15.4	12.6
Ifracombe Torrington Torrington	8,230	2,030	110	13.4	17.2	1	—	—	30	34	68	20	4	2	—	2	4	164	19.9	12.9
	7,280	1,240	108	14.8	17.6	1	1	—	16	17	36	9	—	1	—	4	3	86	11.8	10.9
	7,700	1,730	90	11.7	17.1	1	1	—	22	17	49	10	7	2	—	7	1	115	14.9	8.6
Bideford Holsworthy Great Torrington	11,240	1,530	167	14.9	16.8	—	2	—	31	21	79	20	3	4	—	8	6	172	15.3	11.5
	8,340	1,540	116	13.9	16.1	2	1	—	23	20	43	8	2	1	—	10	6	113	13.5	11.2
	3,080	500	53	17.2	20.5	1	—	—	7	5	33	4	—	2	—	1	2	54	17.5	10.7
Bideford Lynton	5,070	720	65	12.8	14.8	2	—	—	13	10	24	3	1	1	—	6	2	60	11.8	11.1
	1,710	420	18	10.5	12.0	1	—	1	3	4	13	3	—	1	—	3	—	28	16.4	9.5
Salcombe Kingsbridge Kingsbridge	2,420	450	36	14.9	19.8	—	1	—	7	5	7	3	—	2	—	2	—	26	10.7	7.1
	3,510	470	43	12.3	14.4	1	—	—	11	5	19	4	—	1	—	1	—	42	12.0	10.8
	12,080	2,540	157	13.0	15.9	—	—	2	41	24	60	14	6	3	—	6	3	159	13.2	10.7
Plympton St. Mary Tavistock Totnes	13,720	1,730	196	14.3	14.7	1	1	1	35	32	66	18	4	—	—	9	2	167	12.2	10.5
	23,330	3,850	335	14.4	17.3	2	4	2	57	55	132	35	13	5	—	13	5	317	13.6	11.3
	13,960	2,840	182	13.0	16.3	—	—	2	44	59	93	45	3	4	—	8	5	263	18.8	9.4
Totnes Buckfastleigh Dartmouth	5,640	1,180	63	11.2	13.3	—	1	—	14	15	28	11	4	4	—	25	3	104	18.4	10.9
	2,510	460	33	13.1	17.4	1	—	—	10	—	12	4	1	—	—	4	1	32	12.7	9.1
	7,190	1,110	76	10.6	12.0	—	—	—	21	11	27	6	2	2	—	4	4	77	10.7	9.5
Ashburton Dawlish Teignmouth	3,530	600	58	16.4	20.2	1	—	—	10	14	25	9	2	—	—	9	3	72	20.4	13.7
	8,210	2,570	83	10.1	13.6	—	—	4	26	23	59	18	6	1	—	2	2	141	17.2	11.0
	12,260	2,470	130	10.6	16.4	1	—	1	55	43	97	30	4	6	—	5	6	247	20.1	10.5
Newton Abbot Newton Abbot	18,660	3,590	258	13.8	15.3	3	1	5	59	57	116	47	9	5	—	35	11	344	18.4	11.0
	28,610	6,080	395	13.8	16.3	4	2	1	99	49	186	38	8	6	—	16	10	413	14.4	11.1
Okehampton Okehampton	3,790	770	48	12.7	14.4	—	—	—	18	13	32	10	2	2	—	2	1	80	21.1	15.2
	11,210	1,970	136	12.1	15.5	2	2	—	30	26	55	17	4	5	—	12	8	157	14.0	11.2
	Administrative County	84,680	5,954	13.5	16.6	51	38	34	1,321	1,060	2,573	786	169	122	—	333	233	6,631	15.1	10.4

Appendix C

Premature live births in 1969 totalled 334. Of this number only 30 failed to survive the first twenty-eight days of life. Table "A" shows the birth weight, place of birth and number of babies surviving in each group at the end of twenty-eight days.

Table A

Premature live births—Total notified 334														
Weight at birth	Born at home or in a nursing home													
	Born in hospital				Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th Day				Premature Stillbirths	
	Died			Total Births	Died			Total Births	Died			Total Births		
	within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	
1. 2 lb. 3 oz. or less.	6	5	—	—	—	—	—	—	1	—	—	1	8	—
2. Over 2lb. 3 oz. up to and including 3 lb. 4 oz.	22	1	5	—	—	—	—	—	1	1	—	—	4	1
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz.	75	—	7	1	7	—	—	—	—	—	—	—	11	—
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz.	59	1	1	—	1	—	—	—	—	—	—	—	9	1
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz.	151	1	1	2	9	—	—	—	2	—	—	—	3	2
6. Total	313	8	14	3	17	—	—	—	4	—	1	1	35	4

Mortality Rates (Devon and England and Wales)

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
<i>Stillbirths</i>										
Devon	19.0	16.9	15.0	16.9	17.3	15.9	12.1	12.8	11.0	11.6
England and Wales	19.8	19.1	18.1	17.2	16.4	15.7	15.4	14.8	14.0	13.2
<i>Neo-natal Deaths</i>										
Devon	14.3	11.0	11.6	13.6	10.8	9.1	11.5	7.3	8.3	8.6
England and Wales	15.6	15.5	15.1	14.2	13.8	13.0	12.9	12.5	12.3	12.0
<i>Early Neo-natal (1st week) Deaths</i>										
Devon	13.2	9.6	9.5	11.9	9.3	7.5	9.0	5.9	6.1	7.0
England and Wales	13.4	13.4	13.0	12.3	12.1	11.3	11.1	10.8	10.5	10.3
<i>Perinatal Mortality</i>										
Devon	32.0	26.3	24.4	28.5	26.5	23.3	21.0	18.6	17.0	18.6
England and Wales	32.9	32.2	30.8	29.3	28.2	26.9	26.3	25.4	25.0	23.4

CAUSES OF DEATH

Deaths in respect of 1968 are classified under the 65 headings based on the International Abbreviated List (B List) from the manual of the Eighth Revision of the International Classification.

A further 5 headings have been included for 1969.

Principal Causes of Death

The main causes of death remained, in descending order, as in recent years.

The relative contributions of the diseases, which accounted for 90.02% of the total mortality in 1968 and 90.07% in 1969 are indicated below.

Percentage Contribution of Total Causes

<i>Main Causes</i>	1965	1966	1967	1968	1969
Malignant Neoplasms	18.53	18.51	19.04	19.11	19.92
Vascular Lesions of Nervous System	15.94	15.45	16.31	16.29	15.99
Heart and Circulatory Diseases ..	41.63	40.25	40.60	39.16	38.80
Disease of Respiratory System ..	8.42	10.34	8.42	11.81	11.85
Accidents, Suicide and Violence ..	3.51	3.51	3.82	3.65	3.51

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1968

Appendix F

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years								75 and over
						1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	
B.1	Cholera	M	—	—	—	—	—	—	—	—	—	—	—	—
B.2	Typhoid Fever	F	—	—	—	—	—	—	—	—	—	—	—	—
B.3	Bacillary dysentery and amoebiasis	M	—	—	—	—	—	—	—	—	—	—	—	—
B.4	Enteritis and other diarrhoeal diseases	F	—	—	—	1	—	—	—	—	—	1	—	—
B.5	Tuberculosis of respiratory system	M	3	—	2	—	—	—	—	1	—	—	1	2
B.6	Other tuberculosis, including late effects	F	6	—	—	—	—	—	—	—	—	—	4	—
B.7	Plague	M	5	—	—	—	—	—	—	—	—	—	1	1
B.8	Diphtheria	F	1	—	—	—	—	1	—	—	1	1	1	1
B.9	Whooping Cough	M	6	—	—	—	—	—	—	—	—	—	—	—
B.10	Streptococcal sore throat and scarlet fever	F	4	—	—	—	—	—	—	—	—	—	—	—
B.11	Meningococcal infection	M	—	—	—	—	—	—	—	—	—	—	—	—
B.12	Acute poliomyelitis	F	1	—	1	—	—	—	—	—	—	—	—	—
B.13	Smallpox	M	—	—	—	—	—	—	—	—	—	—	—	—
B.14	Measles	F	—	—	—	—	—	—	—	—	—	—	—	—
B.15	Typhus and other rickettsioses	M	—	—	—	—	—	—	—	—	—	—	—	—
B.16	Malaria	F	—	—	—	—	—	—	—	—	—	—	—	—
B.17	Syphilis and its sequelae	M	—	—	—	—	—	—	—	—	—	—	—	—
B.18	All other infective and parasitic diseases	F	1	—	—	—	—	1	1	—	—	—	1	—
B.19(1)	Malignant Neoplasm—stomach	M	1	—	—	—	—	—	—	—	—	—	—	—
B.19(2)	Malignant Neoplasm—lung, bronchus	F	7	—	—	—	—	—	—	—	—	1	2	2
B.19(3)	Malignant Neoplasm—breast	M	5	—	—	—	—	—	—	—	—	—	3	—
B.19(4)	Malignant Neoplasm—uterus	F	78	—	—	—	—	—	—	—	—	13	31	29
B.19(5)	Leukaemia	F	68	—	—	—	—	—	—	—	—	8	21	39
		M	193	—	—	—	—	—	—	1	15	61	83	33
		F	54	—	—	—	—	—	—	—	8	20	16	10
		M	3	—	—	—	—	—	—	—	—	1	2	—
		F	108	—	—	—	—	—	—	7	11	35	29	26
		M	53	—	—	—	—	—	—	4	10	6	13	20
		F	25	—	—	—	—	—	—	3	2	3	6	8
		M	15	—	—	—	—	—	—	1	1	—	4	8

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years								
						1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.19(6)	Other malignant neoplasms etc.	M	343	—	—	1	—	4	7	6	21	65	104	135
B.20	Benign and unspecified neoplasms	F	303	—	—	2	1	1	—	9	21	50	95	124
B.21	Diabetes mellitus	M	6	—	—	—	—	—	—	1	—	2	1	2
B.21	Diabetes mellitus	F	11	—	—	—	1	—	1	—	2	3	—	3
B.22	Avitaminoses	M	24	—	—	—	—	1	1	—	2	6	8	7
B.22	Avitaminoses	F	32	—	—	—	—	—	—	—	2	2	10	17
B.46(1)	Other endocrine diseases etc.	M	—	—	—	—	—	—	—	—	—	—	—	—
B.46(1)	Other endocrine diseases etc.	F	1	1	—	—	—	—	—	—	—	4	1	1
B.23	Anaemias	M	6	—	—	1	—	—	1	—	—	1	—	3
B.23	Anaemias	F	6	—	—	—	—	1	1	—	—	1	—	2
B.46(2)	Other diseases of the blood	M	14	—	—	—	—	—	—	—	—	—	6	8
B.46(2)	Other diseases of the blood	F	3	—	—	1	—	—	—	1	—	—	—	1
B.46(3)	Mental disorders	M	1	—	—	—	—	—	—	—	—	—	—	—
B.46(3)	Mental disorders	F	6	—	—	—	—	—	—	—	—	—	—	5
B.24	Meningitis	M	18	—	—	—	—	—	—	1	—	2	1	8
B.24	Meningitis	F	3	—	—	1	—	—	—	1	1	—	7	—
B.46(4)	Other diseases of nervous system etc.	M	1	—	—	1	—	1	1	—	—	—	—	—
B.46(4)	Other diseases of nervous system etc.	F	24	—	—	1	—	1	—	—	3	4	6	7
B.25	Active rheumatic fever	M	39	—	—	—	—	—	—	—	—	5	13	17
B.25	Active rheumatic fever	F	—	—	—	—	—	—	—	—	—	—	—	—
B.26	Chronic rheumatic heart disease	M	—	—	—	—	—	—	—	—	—	—	—	—
B.26	Chronic rheumatic heart disease	F	22	—	—	—	—	—	—	—	5	6	—	5
B.27	Hypertensive disease	M	37	—	—	—	—	—	—	1	4	7	11	14
B.27	Hypertensive disease	F	64	—	—	—	—	—	—	—	—	12	26	26
B.28	Ischaemic heart disease	M	75	—	—	—	—	—	—	1	—	5	20	49
B.28	Ischaemic heart disease	F	931	—	—	—	—	—	—	18	48	142	339	384
B.29	Other forms of heart disease	M	681	—	—	—	—	—	—	1	8	43	151	478
B.29	Other forms of heart disease	F	152	—	—	—	—	—	—	—	4	10	29	109
B.30	Cerebrovascular disease	M	291	—	—	—	1	1	—	—	—	10	31	248
B.30	Cerebrovascular disease	F	382	1	—	—	—	—	1	2	16	39	121	202
B.46(5)	Other diseases of the circulatory system	M	605	—	1	—	—	1	—	2	16	34	133	418
B.46(5)	Other diseases of the circulatory system	F	150	—	—	—	—	—	—	2	16	12	48	84
B.31	Influenza	M	179	—	—	—	—	—	—	3	3	5	33	138
B.31	Influenza	F	22	—	—	—	—	—	3	1	—	2	3	13
B.32	Pneumonia	M	27	—	—	—	—	—	—	—	1	—	5	21
B.32	Pneumonia	F	177	7	—	—	—	—	1	1	7	16	37	107
B.33(1)	Bronchitis, emphysema	M	243	2	—	—	1	—	—	1	1	10	43	183
B.33(1)	Bronchitis, emphysema	F	175	—	—	—	—	—	1	—	4	23	70	77
B.33(2)	Asthma	M	63	—	—	—	—	—	1	—	4	6	21	31
B.33(2)	Asthma	F	8	—	—	—	—	—	1	—	—	1	5	1
B.46(6)	Other diseases of respiratory system	M	6	—	—	1	—	—	—	2	1	1	1	1
B.46(6)	Other diseases of respiratory system	F	30	1	—	—	1	—	1	—	3	3	13	7
B.34	Peptic ulcer	M	28	—	—	—	—	—	—	—	—	6	2	19
B.34	Peptic ulcer	F	49	—	—	—	—	—	—	—	—	5	17	25
B.35	Appendicitis	M	20	—	—	—	—	—	—	—	—	1	2	17
B.35	Appendicitis	F	2	1	—	—	—	—	—	—	—	—	—	1
			—	—	—	—	—	—	—	—	—	—	—	—

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years								65-74	75 and over
						1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74		
B.36	Intestinal obstruction and hernia ..	M.	5	—	1	—	—	—	—	—	—	—	1	4	
B.37	Cirrhosis of liver ..	F	17	—	—	—	—	—	—	—	—	3	2	11	
B.46(7)	Other diseases of digestive system ..	M	9	—	1	—	—	—	—	1	3	2	3	—	
B.38	Nephritis and nephrosis ..	F	7	—	—	1	—	1	—	—	—	6	8	10	
B.39	Hyperplasia of prostates ..	F	26	—	—	—	—	—	—	—	—	6	10	29	
B.46(8)	Other diseases of genito-urinary system ..	M	47	—	—	—	—	—	—	—	—	3	1	6	
B.40	Abortion ..	F	10	—	—	—	—	—	—	—	—	1	7	6	
B.41	Other complications of pregnancy, etc. ..	F	14	—	—	—	—	—	—	—	—	1	7	6	
B.46(9)	Diseases of skin subcutaneous tissue ..	M	35	—	—	—	—	—	—	2	1	1	8	27	
B.46(10)	Diseases of musculo-skeletal system ..	M	27	—	—	1	—	—	—	—	5	1	6	15	
B.42	Congenital anomalies ..	F	32	—	—	—	—	—	—	—	—	—	—	19	
B.43	Birth injury, difficult labour, etc. ..	F	—	—	—	—	—	—	2	—	—	—	—	—	
B.44	Other causes of perinatal mortality ..	F	2	—	—	2	—	—	—	—	—	—	—	—	
B.45	Symptoms and ill-defined diseases ..	F	3	—	—	—	—	—	—	—	—	—	—	—	
BE.47	Motor vehicle accidents ..	M	20	7	2	—	—	—	—	—	—	—	—	—	
BE.48	All other accidents ..	F	16	9	4	2	—	—	—	—	—	—	—	—	
BE.49	Suicide and self-inflicted injuries ..	M	21	10	—	—	—	—	—	—	—	—	—	—	
BE.50	All other external causes ..	F	10	11	—	—	—	—	—	—	—	—	—	—	
		M	4	4	—	—	—	—	—	—	—	—	—	—	
		F	3	3	—	—	—	—	—	—	—	—	—	—	
		M	28	—	—	—	—	—	—	—	1	—	1	—	
		F	93	—	—	—	—	—	—	—	—	—	—	—	
		M	34	—	—	1	17	—	1	1	3	2	3	3	
		F	20	—	—	1	7	—	1	2	8	6	7	9	
		M	48	—	—	—	—	—	—	—	—	10	11	61	
		F	76	1	1	—	—	—	2	4	—	7	7	4	
		M	30	—	—	—	—	—	—	5	—	6	4	3	
		F	19	—	—	—	—	—	—	—	—	1	—	3	
		M	9	—	—	—	—	—	—	—	—	—	—	—	
		F	5	—	—	—	—	—	—	—	—	—	—	—	
		M	3,207	24	13	12	9	33	26	49	170	470	1,020	1,381	
		F	3,387	26	14	9	8	6	6	37	113	297	725	2,146	
	Total All Causes ..														

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years							65-74	75 and over
						1-4	5-14	15-24	25-34	35-44	45-54	55-64		
B.1	Cholera	M	—	—	—	—	—	—	—	—	—	—	—	—
B.2	Typhoid Fever	F	—	—	—	—	—	—	—	—	—	—	—	—
B.3	Bacillary dysentery and amoebiasis	M	—	—	—	—	—	—	—	—	—	—	—	—
B.4	Enteritis and other diarrhoeal diseases	F	—	—	—	—	—	—	—	—	—	—	—	—
B.5	Tuberculosis of respiratory system	M	1	—	1	1	—	—	—	—	—	—	1	1
B.6	Other tuberculosis, including late effects	F	4	—	—	—	—	—	—	—	—	—	2	1
B.7	Plague	M	3	—	—	—	—	—	—	—	—	—	1	1
B.8	Diphtheria	F	1	—	—	—	—	—	—	—	—	—	1	1
B.9	Whooping Cough	M	8	—	—	—	—	—	—	—	—	—	1	2
B.10	Streptococcal sore throat and scarlet fever	F	5	—	—	—	—	—	—	—	—	—	—	—
B.11	Meningococcal infection	M	—	—	—	—	—	—	—	—	—	—	—	—
B.12	Acute poliomyelitis	F	1	—	1	—	—	—	—	—	—	—	—	—
B.13	Smallpox	M	—	—	—	—	—	—	—	—	—	—	—	—
B.14	Measles	F	—	—	—	—	—	—	—	—	—	—	—	—
B.15	Typhus and other rickettsioses	M	—	—	—	—	—	—	—	—	—	—	—	—
B.16	Malaria	F	—	—	—	—	—	—	—	—	—	—	—	—
B.17	Syphilis and its sequelae	M	—	—	—	—	—	—	—	—	—	—	—	—
B.18	All other infective and parasitic diseases	F	2	—	—	—	—	—	—	1	1	—	1	—
B.19(1)	Malignant Neoplasm—buccal cavity and pharynx	M	6	—	—	—	—	—	—	—	2	1	1	4
B.19(2)	Malignant Neoplasm—oesophagus	F	7	—	—	—	—	—	—	—	1	6	1	5
B.19(3)	Malignant Neoplasm—stomach	M	20	—	—	—	—	—	—	—	—	2	5	4
B.19(4)	Malignant Neoplasm—intestine	F	7	—	—	—	—	—	—	—	2	6	1	10
B.19(5)	Malignant Neoplasm—larynx	M	23	—	—	—	—	—	—	—	1	5	6	8
		F	20	—	—	—	—	—	—	—	4	10	26	41
		M	81	—	—	—	—	—	—	—	—	6	15	35
		F	56	—	—	—	—	—	—	—	—	11	37	39
		M	92	—	—	—	—	1	—	3	1	13	24	49
		F	94	—	—	—	—	—	—	2	5	1	2	1
		M	4	—	—	—	—	—	—	—	—	4	1	3
		F	8	—	—	—	—	—	—	—	—	—	—	—

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years								
						1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.19(6)	Malignant Neoplasm—lung, bronchus	M	234	—	—	—	—	—	—	—	10	64	113	47
B.19(7)	Malignant Neoplasm—breast	F	48	—	—	—	—	—	—	—	7	12	18	11
B.19(8)	Malignant Neoplasm—uterus	M	1	—	—	—	—	—	—	—	1	—	—	—
		F	130	—	—	—	1	—	—	11	22	29	31	36
		F	39	—	—	—	—	—	—	3	2	7	18	9
B.19(9)	Malignant Neoplasm—prostate	M	50	—	—	—	—	—	—	—	—	4	13	33
B.19(10)	Leukaemia	M	30	—	—	—	1	—	—	2	3	2	8	14
		F	16	—	—	—	—	—	1	—	2	3	5	5
B.19(11)	Other Malignant Neoplasms	M	158	—	—	—	2	—	3	6	16	36	57	38
		F	199	—	—	—	1	1	2	4	16	45	61	69
B.20	Benign and unspecified neoplasms	M	5	—	—	—	—	—	—	—	—	1	2	2
		F	6	—	—	—	—	—	—	—	—	1	3	2
B.21	Diabetes mellitus	M	21	—	—	—	—	—	1	1	—	4	6	9
B.22	Avitaminoses	F	37	—	—	—	—	—	—	—	—	6	7	24
		M	2	—	—	—	—	—	—	—	—	1	1	—
B.46(1)	Other endocrine diseases etc	F	1	—	—	—	1	—	—	—	—	—	—	—
		M	9	1	—	—	2	—	—	1	2	4	2	1
B.23	Anaemias	F	10	—	—	—	1	—	—	—	—	—	2	3
		M	8	—	—	—	—	—	—	—	—	—	2	6
B.46(2)	Other diseases of the blood	F	9	—	—	—	—	—	—	—	—	—	1	7
		M	—	—	—	—	—	—	—	—	—	—	—	—
B.46(3)	Mental disorders	F	4	—	—	—	—	—	1	—	—	—	—	—
		M	15	—	—	—	—	—	—	—	—	—	—	3
B.24	Meningitis	F	1	—	—	—	—	—	—	—	1	2	1	11
		M	—	—	—	—	—	—	—	—	—	—	1	—
B.46(4)	Other diseases of nervous system and sense organs	F	—	—	—	—	—	—	—	—	—	—	—	—
		M	28	1	—	—	—	—	3	—	5	4	10	5
B.25	Active rheumatic fever	F	25	—	1	—	1	—	1	—	4	2	6	10
		M	—	—	—	—	—	—	—	—	—	—	—	—
B.26	Chronic rheumatic heart disease	F	18	—	—	—	—	—	—	—	—	—	—	—
		M	37	—	—	—	—	—	—	—	2	3	7	6
B.27	Hypertensive disease	F	58	—	—	—	—	—	—	1	3	10	10	13
		M	69	—	—	—	—	—	—	—	4	11	20	23
B.28	Ischaemic heart disease	F	961	—	—	—	—	—	2	15	1	5	17	46
		M	657	—	—	—	—	—	1	—	50	179	331	384
B.29	Other forms of heart disease	F	163	—	—	—	—	—	1	1	8	62	163	422
		M	275	—	—	—	—	—	—	3	4	15	34	110
B.30	Cerebrovascular disease	F	397	—	—	—	—	—	—	—	1	7	32	232
		M	591	—	—	—	—	—	1	1	11	43	119	220
B.46(5)	Other diseases of the circulatory system	F	136	—	—	—	—	—	2	2	11	41	123	412
		M	199	—	—	—	—	—	—	—	2	8	45	81
B.31	Influenza	F	23	—	—	—	—	—	—	—	2	9	28	160
		M	30	—	—	—	—	—	—	—	2	5	9	6
B.32	Pneumonia	F	185	2	—	—	—	—	—	—	1	4	6	19
		M	238	1	—	—	—	—	—	—	—	—	—	—
		F	—	—	4	—	—	—	1	4	2	10	39	120
			—	—	4	—	—	—	—	1	2	10	49	170

B List Number	Cause of Death	Sex	All Ages	Under 4 Weeks	4 Weeks and Under 1 Year	Age in Years							65-74	55-64	45-54	75 and over
						1-4	5-14	15-24	25-34	35-44	45-54	55-64				
B.33(1)	Bronchitis, emphysema	M	186	—	1	—	—	—	1	—	6	26	86	26	—	66
B.33(2)	Asthma	F	57	—	—	—	—	—	—	—	—	8	18	8	—	31
B.46(6)	Other diseases of respiratory system ..	M	6	—	—	—	—	1	—	1	—	1	3	1	—	1
B.34	Peptic ulcer	F	8	—	—	—	1	—	—	2	1	2	2	2	—	2
B.35	Appendicitis	M	23	—	3	—	—	—	—	—	—	1	6	3	—	10
B.36	Intestinal obstruction and hernia ..	F	30	—	1	2	—	—	—	—	—	3	3	6	—	23
B.37	Cirrhosis of liver	M	19	—	—	—	—	—	—	—	—	1	7	7	—	9
B.46(7)	Other diseases of the digestive system ..	F	21	—	—	—	—	—	—	—	—	—	1	—	—	13
B.38	Nephritis and nephrosis	M	4	—	—	—	—	—	—	—	—	—	2	—	—	2
B.39	Hyperplasia of prostate	F	19	2	—	—	—	—	—	—	1	2	2	—	—	12
B.46(8)	Other diseases of genito-urinary system ..	M	11	—	—	—	—	—	—	—	1	2	3	1	—	7
B.40	Abortion	F	10	—	—	—	—	—	—	—	1	2	3	2	—	3
B.41	Other complications of pregnancy, childbirth and puerperium	M	4	—	—	—	—	—	—	—	2	9	10	—	—	6
B.46(9)	Diseases of the skin and subcutaneous tissue ..	F	31	—	—	—	—	—	1	1	3	4	13	—	—	27
B.46(10)	Diseases of the musculo-skeletal system and connective tissue	M	45	—	—	—	—	—	2	—	—	—	10	—	—	3
B.42	Congenital anomalies	F	16	—	—	—	—	—	1	—	—	3	9	—	—	5
B.43	Birth injury, difficult labour, and other anoxic and hypoxic conditions	M	12	—	—	—	—	—	—	—	—	4	2	—	—	22
B.44	Other causes of perinatal mortality	F	9	9	5	1	1	—	—	2	1	1	7	—	—	14
B.45	Symptoms and ill-defined conditions	M	7	2	6	—	—	—	—	1	—	—	1	—	—	26
BE.47	Motor vehicle accidents	F	8	12	—	—	—	—	—	—	—	—	—	—	—	—
BE.48	All other accidents	M	43	7	—	—	—	—	—	—	—	1	—	—	—	—
BE.49	Suicide and self-inflicted injuries	F	79	—	—	—	—	—	—	—	—	—	—	—	—	—
BE.50	All other external causes	M	29	—	—	—	—	—	—	—	—	—	—	—	—	—
		F	14	—	—	—	—	—	—	—	—	—	—	—	—	—
		M	48	—	3	—	—	8	1	3	2	8	1	8	2	41
		F	75	—	2	—	—	3	7	6	5	3	2	3	7	78
		M	26	—	—	—	—	2	1	1	2	7	1	1	1	3
		F	27	—	—	—	—	1	1	1	7	7	6	3	6	5
		M	12	—	—	—	2	—	—	4	4	8	12	7	10	48
		F	2	1	—	—	—	—	4	2	1	—	—	—	2	2
		M	2	1	—	—	—	—	—	—	—	—	—	—	—	—
Total All Causes	.. ..	M	3,305	32	20	4	11	21	27	51	156	507	1,057	507	156	1,419
		F	3,326	19	18	4	5	12	12	36	109	338	716	338	109	2,057

Appendix G

In 1965 the Ministry of Health revised the age groupings, hence the changed setting of the table as from that year.

Diphtheria (including combined immunisation)

Year	No. of children who completed a full course of immunisation							Booster
	Under 1	1–	2–	3–	4–7	Others under age 16	Totals	
1968	2,301	2,414	221	72	271	162	5,441	7,991
1969	1,204	2,451	222	61	206	110	4,254	6,706

Whooping Cough (including combined immunisation)

The number of children protected against whooping cough during 1969 is as follows:

	Year of birth					Others under age 16	Total	Booster
	1969	1968	1967	1966	1962–65			
A.C.M.O's.	315	231	41	5	7	24	623	326
G.P's. ..	876	2,195	167	52	92	35	3,417	2,323
Total ..	1,191	2,426	208	57	99	59	4,040	2,649

Tetanus (including combined immunisation)

The number of children protected against tetanus during 1969 is as follows:

	Year of birth					Others under age 16	Total	Booster
	1969	1968	1967	1966	1962–65			
A.C.M.O's.	320	232	48	8	76	390	1,074	3,412
G.P's. ..	894	2,227	176	55	151	356	3,859	4,639
Total ..	1,214	2,459	224	63	227	746	4,933	8,051

Sabin (Oral)

The number of children protected against oral poliomyelitis during 1969 is as follows:

	Year of birth					Others under age 16	Total	Booster
	1969	1968	1967	1966	1962–65			
A.C.M.O's.	298	222	53	5	76	40	694	3,880
G.P's. ..	799	2,355	284	83	171	99	3,791	3,319
Total ..	1,097	2,577	337	88	247	139	4,485	7,199

Smallpox

The following table shows the number of smallpox vaccinations and re-vaccinations performed during the last two years.

Vaccinations						Re-Vaccinations				
Year	Under 1	1	2-4	5-14	Total	Under 1	1	2-4	5-14	Total
1968	354	1,952	1,470	317	4,093	—	26	74	709	809
1969	215	1,657	1,297	222	3,391	—	21	105	875	1,001

B.C.G. (Anti-Tuberculosis) 1968

	School Children	Students Attending Further Education Establishments
No. of Children on Roll	4,600	30
No. of children for whom parental consent received	3,742	30
No. tuberculin tested (Heaf tested 2 mm. puncture)	3,615	30
No. positive	266	3
No. negative	3,604	24
No. given freeze-dried B.C.G. vaccine	2,905	24

B.C.G. (Anti-Tuberculosis) 1969

	School Children	Students Attending Further Education Establishments
No. of Children on Roll	4,389	5
No. of children for whom parental consent received	4,208	2
No. tuberculin tested (Heaf tested 2 mm. puncture)	3,897	2
No. positive	208	1
No. negative	3,563	1
No. given freeze-dried B.C.G. vaccine	3,493	1

HEAF TEST

In accordance with the decision reached in 1966, only school entrants were Heaf tested during 1968.

The figures for the year 1st November, 1967 to 31st October 1968, are as follows:

	Found Positive on first testing	Converted to Positive on subsequent test	Total
Found Positive	57	9	66
Positive Children X-rayed ..	32	—	32
Contacts X-rayed:			
(Adults)	34	—	34
(Children)	10	—	10
Cases picked up:			
Positive Children	—	—	—
Adult Contacts	—	—	—
Child Contacts	—	—	—
No. of schools tested—181. No. of children tested (all ages)—4,391.			

The figures for the year 1st November, 1968 to 31st October, 1969 are as follows:

	Found Positive on first testing	Converted to Positive on subsequent test	Total
Found Positive	48	6	54
Positive Children X-rayed ..	25	—	25
Contacts X-rayed:			
(Adults)	26	—	26
(Children)	7	—	7
Cases picked up:			
Positive Children	—	—	—
Adult Contacts	—	—	—
Child Contacts	—	—	—
No. of schools tested—241. No. of children tested (all ages)—5,075.			

Appendix H

Allocation of Sessions

	1969	1968	1967
<i>Dental Treatment</i>			
Schools	5,548	5,476	6,821
Pre-School	182	146	135
Expectant and Nursing Mothers	29	32	35
Junior Training Centres.. ..	10	13	15
Adult Workshops	55	49	30
Total*	5,824	5,716	7,036

* This total includes 64 Dental Officer Anaesthetist sessions in 1969 and 46 in 1968.

	1969	1968	1967
<i>Inspections</i>			
Schools	733	594	691
Child Health Clinics	89	57	37
Junior Training Centres ..	4	5	5
Adult Workshops	7	7	4
Total	833	663	737

DENTAL TREATMENT—SCHOOL CHILDREN

	1969			1968*	1967
	5-9	10-14	15+	Total	Total
1 Attendances for Treatment (including Orthodontic and Emergency) ..	17,720	18,821	3,908	40,449	35,792
2 Emergencies	460	230	57	747	728
3 Number Actually Treated	7,422	5,358	1,152	13,932	12,848
4 Additional Courses of Treatment Commenced	1,665	1,495	333	3,493	2,285
5 Fillings—Permanent Teeth	7,328	16,067	4,200	27,595	24,989
„ Deciduous Teeth	14,194	1,013	—	15,207	12,017
6 Teeth Filled—Permanent Teeth ..	6,327	14,531	3,897	24,755	22,976
„ „ Deciduous Teeth	13,365	975	—	14,340	11,317
7 Extractions—Carious—Permanent Teeth	178	615	157	950	1,060
Extractions—Deciduous Teeth ..	3,896	1,170	—	5,066	4,911
8 Extractions—Orthodontic—Permanent Teeth	33	663	67	763	552
Deciduous Teeth	293	292	—	585	342
9 No. of General Anaesthetics—By Medical Anaesthetists	380	217	17	614	444
By Dental Officers	424	146	8	578	494
10 Patients X-rayed	272	929	157	1,358	1,072
11 Prophylaxis	1,709	2,631	631	4,971	4,662
12 Gum Treatment	139	278	119	536	337
13 Teeth Otherwise Conserved	1,252	82	7	1,341	1,500
14 Other Operations—Permanent Teeth	471	940	249	1,660	807
Deciduous Teeth	1,136	97	2	1,235	512
15 Teeth Root Filled	8	41	13	62	52
16 Inlays	—	4	1	5	6
17 Crowns	—	6	4	10	15
18 Number of Dentures Fitted	3	37	14	54	56
19 All Courses of Treatment Completed	8,246	6,167	1,319	15,732	13,669

Appendix H

	1969	1968	1967
20 Orthodontics:			
(a) Cases Remaining From Previous Year	314	219	380
(b) New Cases Commenced During Year	404	259	170
(c) Cases Completed During Year ..	229	140	113
(d) Cases Discontinued During Year	41	23	14
(e) No. of Removable Appliances Fitted	495	430	388
(f) No. of Fixed Appliances Fitted ..	10	21	20
(g) Cases Referred to Hospital Consultant	160	169	137
(h) Attendances for Orthodontics ..	5,765	3,532	**

* These totals do not include Torbay returns for the first quarter of the year.

** Totals not available.

	First Examination During Year					Second and Subsequent Examination During Year			
	Number Inspected	Number Found To Require Treatment	Number Offered Treatment	Number For Treatment Consented		Number Inspected	Number Found To Require Treatment	Number Offered Treatment	Number For Treatment Consented
1969	<i>School Children</i>					13,388 2,691	5,721 2,173	4,665 2,170	2,402 2,124
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1968	Total	16,079 7,331 1,371	7,894 3,846 969	6,835 3,148 *	4,526 2,374 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1969	<i>Pre-School Children</i>					471 162 *	231 86 *	225 86 *	224 86 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1968	Total	122 43 *	46 15 *	46 15 *	25 9 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1967	<i>Junior Training Centres</i>					6 3 *	6 3 *	6 3 *	6 3 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1969	Total	121 5 *	52 5 *	52 5 *	40 5 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1968	<i>Expectant and Nursing Mothers</i>					74 *	74 *	74 *	74 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1967	Total	77 79 *	103 98 88	77 79 *	65 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1969	<i>Adult Workshops</i>					228 204 131	103 98 88	77 79 *	65 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1968	Total	224 86 *	231 86 *	225 86 *	224 86 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1967	<i>Expectant and Nursing Mothers</i>					99 87 105	74 83 88	74 82 84	74 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1969	Total	228 204 131	103 98 88	77 79 *	65 *
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
1968	<i>Adult Workshops</i>					228 204 131	103 98 88	77 79 *	65 *
	No. Inspected at School	..	..	..	..
	No. Inspected at Clinic	..	..	..	..
	Total Inspected at School and Clinic	..	..	..	..
1967	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..
	Total ..	..	..	..	..

* Totals Not Available.

DENTAL TREATMENT—OTHER CLASSES

Appendix H

	Pre-School Children			Expectant and Nursing Mothers			Junior Training Centres			Adult Workshops		
	1969	1968	1967	1969	1968	1967	1969	1968	1967	1969	1968	1967
1 Attendances for Treatment (including “Emergency” and “Orthodontic”)	1,326	960	811	210	206	212	73	86	96	397	322	205
2 Emergencies	58	44	37	6	9	9	—	—	—	6	3	—
3 Number Actually Treated	592	431	382	71	70	87	44	50	63	94	80	74
4 Additional Courses of Treatment Commenced	150	68	39	6	3	6	14	5	—	25	9	—
5 Fillings—Permanent Teeth	—	—	—	125	117	160	42	82	96	223	125	60
5 Fillings—Deciduous Teeth	1,496	978	688	—	—	—	40	14	—	—	—	—
6 Teeth Filled—Permanent Teeth	—	—	—	122	108	125	39	76	*	203	118	*
6 Teeth Filled—Deciduous Teeth	1,418	925	602	—	—	—	34	14	*	—	—	—
7 Extractions—Permanent Teeth	—	—	—	55	71	59	2	4	18	103	70	53
7 Extractions—Deciduous Teeth	237	204	243	—	—	—	17	3	—	—	—	—
8 No. of General Anaesthetics—By Medical Anaesthetists..	46	52	67	2	1	2	1	1	—	2	5	7
8 No. of General Anaesthetics—By Dental Officers..	23	22	19	2	5	4	1	—	1	1	1	7
9 Patients X-rayed	7	7	4	17	5	9	—	—	—	22	8	7
10 Prophylaxis	123	71	67	54	41	56	7	6	13	77	44	35
11 Teeth Otherwise Conserved	123	128	162	—	2	—	—	—	—	2	1	—
12 Other Operations	177	115	*	57	12	*	8	13	3	118	37	40
13 Teeth Root Filled	3	—	—	—	—	—	—	—	—	—	—	—
14 Inlays and Crowns	—	—	—	—	—	1	—	—	—	—	—	—
15 Number of Dentures Fitted	—	—	—	12	12	13	—	—	—	12	23	19
16 All Courses of Treatment Completed	637	428	306	59	55	68	52	38	26	82	69	40

* Totals not available.

EPIDEMIOLOGY

Incidence and Notification of Infectious Diseases

This table affords a comparison with the preceding five years:

	Number of Corrected Notifications					
	1964	1965	1966	1967	1968	1969
Measles	2,679	5,863	2,700	5,498	2,506	765
Whooping Cough	322	89	175	133	170	47
Diphtheria	1	—	—	—	—	1
Poliomyelitis	—	—	—	—	—	—
Scarlet Fever	142	145	140	131	72	64
*Erysipelas	24	25	14	11	11	—
*Pneumonia	121	81	129	90	75	—
Meningitis	8	4	3	7	5	2
Tuberculosis	110	131	122	73	62	51
Typhoid or Paratyphoid	3	—	—	2	1	—
Dysentery	70	52	109	174	90	108
Food Poisoning	87	26	48	6	13	87
Ophthalmia Neonatorum	2	—	8	—	—	—
*Puerperal Pyrexia	10	8	6	—	1	—
Smallpox	—	—	—	—	—	—
Acute Encephalitis	—	—	—	—	—	1
Anthrax	—	—	—	—	—	—
†Infective Jaundice	—	—	—	—	56	73
‡Yellow Fever	—	—	—	—	—	—
‡Tetanus	—	—	—	—	—	—
Leptospirosis	—	—	—	—	—	—
Leprosy	—	—	—	—	—	—
Cholera	—	—	—	—	—	—
Plague	—	—	—	—	—	—
Relapsing Fever	—	—	—	—	—	—
Typhus	—	—	—	—	—	—

* Not notifiable with effect from 1.10.68.

† Notifiable with effect from 1.4.68.

‡ Notifiable with effect from 1.10.68.

For the ninth year in succession, no cases of poliomyelitis were notified in Devon and this is considered to be mainly due to the successful vaccination campaign.

There were more cases of dysentery this year, and this together with the 87 cases of food poisoning shows an obvious need for more personal hygiene education, particularly of those handling food.

Venereal Diseases

	New Cases Treated					
	1964	1965	1966	1967	1968	1969
Syphilis	18	14	15	12	3	9
Gonorrhoea	106	102	104	164	102	101
Other conditions	279	374	447	512	325	411

Venereal diseases are not notifiable and the figures shown above are only in respect of cases treated at the special centres. It is obvious that these figures are an unknown fraction of the total cases of venereal disease occurring in the area.

TUBERCULOSIS 1968

This year 62 cases were notified, a fall over last year of 11.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1968	1967	1966	1965	1964
Under 5	2	—	—	—	2	—	2	2	4	4	2
5—14	—	1	1	—	1	1	2	1	6	11	9
15—24	2	1	—	3	2	4	6	5	17	19	14
25—34	1	1	—	1	1	2	3	8	13	19	14
35—44	6	1	—	3	6	4	10	11	14	19	20
45—54	5	2	1	—	6	2	8	11	26	22	15
55—64	11	—	—	3	11	3	14	8	20	17	12
65+	9	2	1	5	10	7	17	27	22	19	23
Unknown	—	—	—	—	—	—	—	—	—	1	1
Totals	36	8	3	15	39	23	62	73	122	131	110
	44		18		62						

TUBERCULOSIS 1969

This year 51 cases were notified, a fall over last year of 11.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1969	1968	1967	1966	1965
Under 5	2	1	1	—	3	1	4	2	2	4	4
5—14	—	—	—	—	—	—	—	2	1	6	11
15—24	1	3	1	—	2	3	5	6	5	17	19
25—34	1	2	1	1	2	3	5	3	8	13	19
35—44	1	—	—	1	1	1	2	10	11	14	19
45—54	7	—	—	3	7	3	10	8	11	26	22
55—64	4	3	—	3	4	6	10	14	8	20	17
65+	8	1	1	5	9	6	15	17	27	22	19
Unknown	—	—	—	—	—	—	—	—	—	—	1
Totals	24	10	4	13	28	23	51	62	73	122	131
	34		17		51						

Treatment—Chest Clinics. The work of the four chest clinics for the year 1968 is summarised in the table below:

	Torquay	Barnstaple	Exeter	Plymouth	Total
Patients on Register 1.1.68 ..	533	240	436	59	1,268
New Notifications:					
(a) respiratory	5	9	21	11	46
(b) non-respiratory	2	2	10	1	15
Deaths	16	3	10	7	36
Patients on Register 31.12.68	386	178	415	39	1,018
First examination of suspects	1,044	100	968	386	2,498
Cases of T.B. found	28	2	17	9	56
Contacts examined	158	76	146	35	445
Cases of T.B. found in contacts	1	3	2	3	9
Contacts vaccinated with B.C.G.	27	51	105	21	204

Treatment—Chest Clinics. The work of the four chest clinics for the year 1969 is summarised in the table below:

	Torquay	Barnstaple	Exeter	Plymouth	Total
Patients on Register 1.1.69 ..	78	178	415	39	710
New Notifications:					
(a) respiratory	5	5	16	14	40
(b) non-respiratory	2	7	11	1	21
Deaths	8	—	13	12	33
Patients on Register 31.12.69	63	174	405	34	676
First examination of suspects	244	140	696	532	1,612
Cases of T.B. found	12	3	27	11	53
Cases of positive sputum ..	6	3	25	4	38
Contacts examined	75	70	41	35	221
Cases of T.B. found in contacts	1	—	1	—	2
Contacts vaccinated with B.C.G.	21	34	125	36	216

TUBERCULOSIS

Deaths from Tuberculosis, 1968

Clasification	Age Groups																Total		Grand Total
	0–		1–		5–		15–		25–		45–		65–		75–				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	—	—	1	—	—	—	4	—	—	1	5	1	6
Non-Respiratory	—	—	—	—	—	—	—	1	—	—	2	1	3	1	1	1	6	4	10
Totals	—	—	—	—	—	—	—	1	1	—	2	1	7	1	1	2	11	5	16

The deaths in this group were six less than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication. It should be noted that 68% of deaths occurred in persons over 65.

TUBERCULOSIS

Deaths from Tuberculosis, 1969

Classification	Age Groups																Total		Grand Total
	0–		1–		5–		15–		25–		45–		65–		75–				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	—	—	—	—	—	—	2	1	1	—	3	1	4
Non-Respiratory	—	—	—	—	—	—	—	—	—	—	6	2	1	1	1	2	8	5	13
Totals	—	—	—	—	—	—	—	—	—	—	6	2	3	2	2	2	11	6	17

The deaths in this group were one more than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication. It should be noted that 53% of deaths occurred in persons over 65.

OCCUPATIONAL THERAPY

Number of patients receiving domicilliary occupational therapy in 1968—1,729; in 1969—2,642

	Boys		Girls		Men		Women		Total
	1968	1969	1968	1969	1968	1969	1968	1969	1969
Physically disabled ..	5	9	8	15	574	896	1,020	1,635	2,555
Mentally Ill ..	—	—	—	—	28	20	23	20	40
Mentally Subnormal	9	5	15	2	23	24	24	16	47
Severely Mentally Subnormal ..	—	—	—	—	—	—	—	—	—
Totals.. ..	14	14	23	17	625	940	1,067	1,671	2,642

HOME HELP SERVICE

Statistics for the year ended 31st December, 1968

	Over 65	Under 65				Totals
		Chronic Sick including T.B.	Mentally Disordered	Maternity	Others	
D.C.C. Organisers ..	3,733	339	39	253	427	4,791
W.R.V.S. Dartmouth	35	5	—	1	2	43
Totals for 1968, inc. Transfers to Torbay C.B.	3,768	344	39	254	429	4,834

At 31st March, 1968 the following cases were transferred to Torbay C.B.	1,016	109	13	62	50	1,250
D.C.C. cases 1.4.68 ..	2,046	133	20	47	287	2,533
D.C.C. cases 1.4.68 to 31.12.68	706	102	6	145	92	1,051
Totals for year ..	3,768	344	39	254	429	4,834

Statistics for the year ended 31st December, 1969

	Over 65	Under 65				Totals
		Chronic Sick including T.B.	Mentally Disordered	Maternity	Others	
D.C.C. Organisers ..	2,947	248	30	175	301	3,701
W.R.V.S. Dartmouth	33	6	—	1	3	43
Total cases for 1969 ..	2,980	254	30	176	304	3,744

SOCIAL WORKERS IN MENTAL HEALTH

It should be noted that all 1968 figures have decreased considerably due to the transfer of Torbay to the new County Borough.

Total Case Load (All Types of Mentally Disordered Persons)

	1965	1966	1967	1968	1969
Total Case Load	2,543	2,556	2,389	1,949	1,875

Analysis of Referrals to Social Workers

Sources of referral of all categories of new patients	1965	1966	1967	1968	1969
General Practitioners	979	1,217	1,391	856	1,150
Hospitals, on Discharge	539	529	521	361	447
Hospitals, Out-Patients Department ..	437	330	195	148	73
Police and Courts	72	146	126	66	58
Other Sources	313	300	387	339	323
Total Referrals	2,340	2,522	2,620	1,770	2,051

Mental Illness

No. of Social Workers Visits	1965	1966	1967	1968	1969
Known mentally ill adults in the community	1,673	1,505	1,612	1,244	1,197
Visits to patients	17,868	20,599	22,981	14,468	16,326

Social Worker Visits in respect of Hospital Admissions and Discharges of the Mentally Ill

Mental Health Act 1959	Exe Vale Hospital		Moorhaven Hospital		Out-County Hospitals		1965	1966	1967	1968	1969
	1968	1969	1968	1969	1968	1969					
Informal Patients (Sect. 5)	1,086	990	133	149	6	1	1,471	1,263	1,439	1,225	1,140
Observation (Sect. 25)	86	60	12	16	—	1	151	188	140	98	77
Treatment (Sect. 26)	12	15	9	2	—	1	17	30	44	21	18
Emergencies (Sect. 29)	204	150	19	7	—	2	312	349	285	223	159
Courts (Sect. 60)	9	8	1	1	..—..	1	19	10	16	10	10
Total Admissions	1,397	1,223	174	175	6	6	1,970	1,840	1,924	1,577	1,404
Total Discharges	997	932	18	15	6	1	1,604	1,332	1,349	1,021	948
Re-admissions (included in the totals)							519	281	369	233	241
Visits by social workers in respect of admission							4,090	3,929	3,727	2,153	2,267

Subnormal School-leavers

	1965	1966	1967	1968	1969
Number of special school and junior training centre leavers placed under community care	30	42	39	36	35
Number of children classified as educationally subnormal leaving secondary schools and placed under community care	20	27	30	32	38
Totals	50	69	69	68	73

Subnormal Adults

	1965	1966	1967	1968	1969
Discharged from hospital to community care	89	11	30	18	39
Guardianship cases	1	1	1	1	1
Discharged from community care ..	76	103	144	166	181
Total visits by social workers ..	4,562	4,134	4,603	3,925	3,614
Total active case load	922	851	775	705	678

Hospital Admissions and Discharges of the Subnormal

Mental Health Act 1959	R.W.C. Hospital		Special Hospitals		Out-County Hospitals		1965	1966	1967	1968	1969
	1968	1969	1968	1969	1968	1969					
Admissions: Informal Patients (Sect. 5)	25	26	—	—	—	3	25	19	38	25	29
Observation (Sect. 25)	2	—	—	—	—	1	1	1	—	2	1
Treatment (Sect. 26)	1	2	—	—	—	—	—	—	1	1	2
Emergencies (Sect. 29)	—	—	—	—	—	—	2	—	—	—	—
Courts (Sect. 60)	3	3	—	—	2	—	8	7	5	5	3
Total Admissions	31	31	—	—	2	4	36	27	44	33	35
Total Discharges	—	12	—	—	—	—	46	16	44	16	12
Temporary hospital admissions (not exceeding two months)							19	9	18	12	16
Visits by social workers in respect of admissions							130	108	150	110	114

Hospital Waiting List of the Subnormal

					Boys	Girls	Men	Women	Total
1964	..	..	..	..	14	9	10	4	37
1965	18	12	14	5	49
1966	17	11	16	5	49
1967	17	8	14	9	48
1968	12	6	9	6	33
1969	11	4	7	9	31

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